Utah Violence and Injury Prevention Plan Across the Lifespan 2016-2020

Violence and Injury Prevention Program

"We are a trusted and comprehensive resource for data related to violence and injury. Through education, this information helps promote partnerships and programs to prevent injuries and improve public health."

Acknowledgements

This plan could not have been completed without the support and guidance of the Injury Community Planning Group (ICPG) and the following subcommittees:

- Domestic Violence Fatality Review Committee
- Child Fatality Review Committee
- Pain Medication Education Advisory Group
- Utah Sexual Violence Council
- Utah Suicide Prevention Coalition
- Teen Driving Task Force
- Utah Falls Prevention Coalition
- Utah Safe Kids Coalition
- Utah Healthy Relationships Task Force

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- Alpine School District
- Hawthorne Academy
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- Murray Police Department
- Murray School District
- New Horizons Crisis Center
- Prevent Child Abuse Utah
- Provo City School District
- Utah Falls Prevention Coalition
- Utah Brain Injury Council
- Utah Suicide Prevention Coalition & Executive Committee

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Planning Process

Starting in 2009, the Utah Department of Health Violence and Injury Prevention Program (VIPP) conducted a needs assessment, survey, focus groups, and strategic planning sessions with key partners to develop the Utah Violence and Injury Prevention across the Lifespan plan. VIPP epidemiologists analyzed emergency department, hospital discharge, and mortality data by age, sex, race, ethnicity, small area, and local health district to determine the magnitude of violence and injury in Utah. The results of their findings were presented to the VIPP staff, Injury Community Planning Group (ICPG), and ICPG subcommittees. A survey was also conducted with partners to determine capacity and resources in the state.

The ICPG subcommittees include: 1) Family Violence (Domestic Violence and Child Fatality ICPG members), 2) Sexual Violence Prevention, 3) Motor Vehicle ICPG (Teen Driving Task Force), 4) Pain Medication Education Advisory Group, 5) Suicide Prevention Task Force, 6) Utah Falls Prevention Coalition, and 7) Utah Safe Kids Coalition.

Priorities were established using the Hanlon Method, also known as the Basic Priority Rating System. This model allowed VIPP staff and the ICPG to: 1) identify factors to be considered in setting priorities, 2) organize the factors into groups that were weighted relative to each other, and 3) allow the factors to be modified as needed and scored individually. Factors that were considered for each topic included the size of the problem, seriousness of the problem, effectiveness of intervention, and PEARL factors (propriety, economic feasibility, acceptability, resource availability, and legality). After these components were considered, a score was calculated for each topic. Through this process, it was determined that the plan should focus on prevention over the lifespan of Utah residents in order to most effectively use resources, collaborate with partners, and prevent injury. The priorities by lifespan:

Age Group	Injury Priorities
Birth-12	• Child Maltreatment • Infant Sleep-related Fatalities • School-related Injuries
13-17	• Motor Vehicle Crashes • Prescription Drug Abuse and Overdose • Suicide Attempts and Fatalities • Youth Violence
18-24	• Motor Vehicle Crashes • Poisoning (Prescription and Illicit Drugs) • Domestic Violence and Sexual Violence • Suicide Attempts and Fatalities
25-64	• Motor Vehicle Crashes • Poisoning (Prescription Drugs) • Domestic Violence and Sexual Violence
65+	• Falls • Motor Vehicle Crashes • Suicide Fatalities

The plan is organized by lifespan and sectioned into age groups. The following is discussed for each topic according to age group: 1) Overview, 2) Data, Surveillance, and Costs, 3) Healthy People 2020 Objectives, 4) Prevention Strategies, 5) Implementing Organizations, and 6) Evidence-based Interventions/Best Practices. The plan also includes a data profile of Utah and a summary table with age-adjusted rates for each topic that includes U.S., Utah, local health district, small area, and sex data. Age specific rates are also provided. In addition, each of the rates is color-coded to signify whether they are higher, lower, or the same as the state rate. Rates for Utah's 61 small areas are ranked for each topic based on the age-adjusted rate, denoting their position compared to other small areas in the state.

The plan illustrates the use of the ICPG and the ICPG subcommittees' knowledge and expertise to determine critical target areas for each priority. For example, along with the available sexual violence data presented, the Sexual Violence Prevention ICPG subcommittee conducted a needs assessment, focus groups, and capacity surveys to determine critical target areas in the sexual violence field. Due to this process, sexual violence priorities are targeted for persons 18-24 and 25-64 years of age. In addition, based on data and the additional work of the Sexual Violence ICPG subcommittee, disparate populations (geographic, race, sexual orientation, etc.), are also identified as critical target areas.

As another example, feedback on motor vehicle safety was obtained during focus groups in the summer of 2010 with partners including the Utah Local Association of Community Health Educators, Utah Teen Traffic Safety Task Force, Safe Kids Utah and local Safe Kids

Chapters/Coalitions, and seniors at the Riverton Senior Center. The following questions were asked of each group with respect to the population they targeted:

1. What has public health and our allied partners done well related to motor vehicle safety in the last 2-3 years?
2. As public health, or in coordination with our allied partners, what would you like to see accomplished in Utah related to motor vehicle safety in the next five years?

Responses to these questions helped to develop the recommended strategies for each age group. In sum, the data was used by each ICPG subcommittee to establish critical target areas by identifying geographic and demographic risk factors for each injury priority.

Demographic data with rates that were significantly higher compared to the state rate were utilized to set objectives and activities. Specific, measurable, achievable, and realistic priorities (SMART) were developed with timeframes consistent with the state plan timeline. In addition, the National Registry of Evidence-based Programs and Practices (NREPP), along with other federal agencies that have identified evidence-based or best practice interventions, were included in the plan for each priority. Implementing organizations were identified by the ICPG and ICPG subcommittees based on the organization's knowledge, expertise, and ability to carry out priority strategies.

The plan is a framework that will guide surveillance, partnership building, prevention, and policy development in Utah. It will include additional injury focus areas in the future, dependent on data discoveries, trends, or emerging issues. The plan serves as a tool to build social capital and resources to support injury prevention efforts to reduce injuries and save lives. The plan is meant to be a working document and will be continually updated.

Utah State Profile

The western state of Utah shares its borders with Arizona to the south, Idaho and Wyoming to the north, Colorado to the east, and Nevada to the west. The state contains a diverse mix of terrain that ranges from mountainous landscape to basins, canyons, and valleys. Utah is 84,900 square miles and ranked the 11th largest state (in terms of square miles) in the U.S. The name "Utah" comes from the American Indian "Ute" tribe and means "people of the mountains."[1]

Population

In 2000, Utah's population was 2,233,169.[2] Since then, the state's population has steadily increased. The Utah Governor's Office of Planning and Budget (GOPB) estimates population by fiscal year. The estimated population of Utah as of July 1, 2011 was 2,813,923. Since then the state has been increasing in population and is approaching three million residents (Figure X).[2]

Figure X

Number in the Population by Year, Utah (2004-2014)
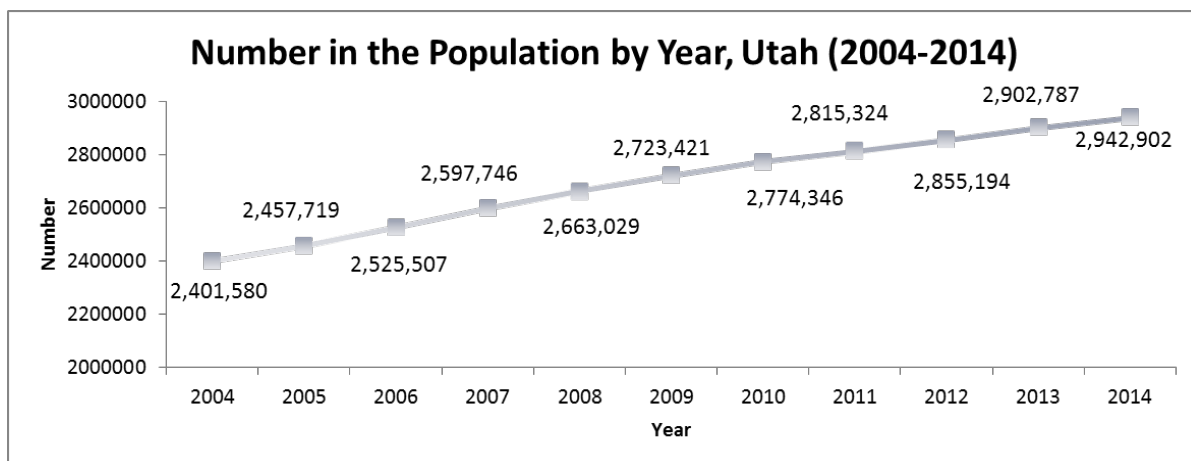
There are a total of 29 counties in Utah. There are four urban counties in Utah which make up an area called the Wasatch Front. This area consists of 75.5% of the population and includes Davis, Salt Lake, Utah, and Weber Counties (Figures X and X). Urban areas are defined as having 100 or more persons per square mile. Salt Lake City, the capital of Utah, is the largest city and

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[1] *"Quick Facts About Utah's History and Land" Utah.gov. 2009. 3 March 2009.*
http://www.utah.gov/about/quickfacts.html
[2] *The Utah Population Estimates Committee (UPEC) and the Governor's Office of Planning and Budget (GOPB), Estimates for Counties by Sex and Single Year of Age. For more information, go to* http://www.governor.utah.gov/dea/demographics.html.

is centered in the Wasatch Front area. Twelve counties make up the rural areas of Utah and consist of 20.9% of the population (Figures X and X). Rural areas are defined as having more than six but less than 100 persons per square mile. Thirteen counties make up the frontier areas and consist of 3.7% of the population (Figures X and X). Frontier areas are defined as having six or fewer persons per square mile.[3]

Figure X

Percentage of Population Density by Land Area, Utah 2014, N=2,942,902

Figure X
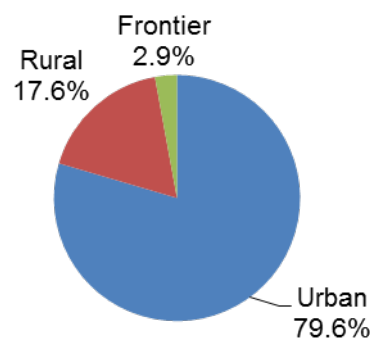
Population Density by Land Area, Utah 2014

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[3] *Office of Vital Records and Statistics, Utah Department of Health, U.S. Census, Utah Population Estimates Committee and the Governor's Office of Planning and Budget, 2008 Baseline Economic and Demographic Projections (Revised on 7-23-2008).*

Population Density by Land, Area and County of Residence, Utah , 2014

URBAN
RURAL
FRONTIER
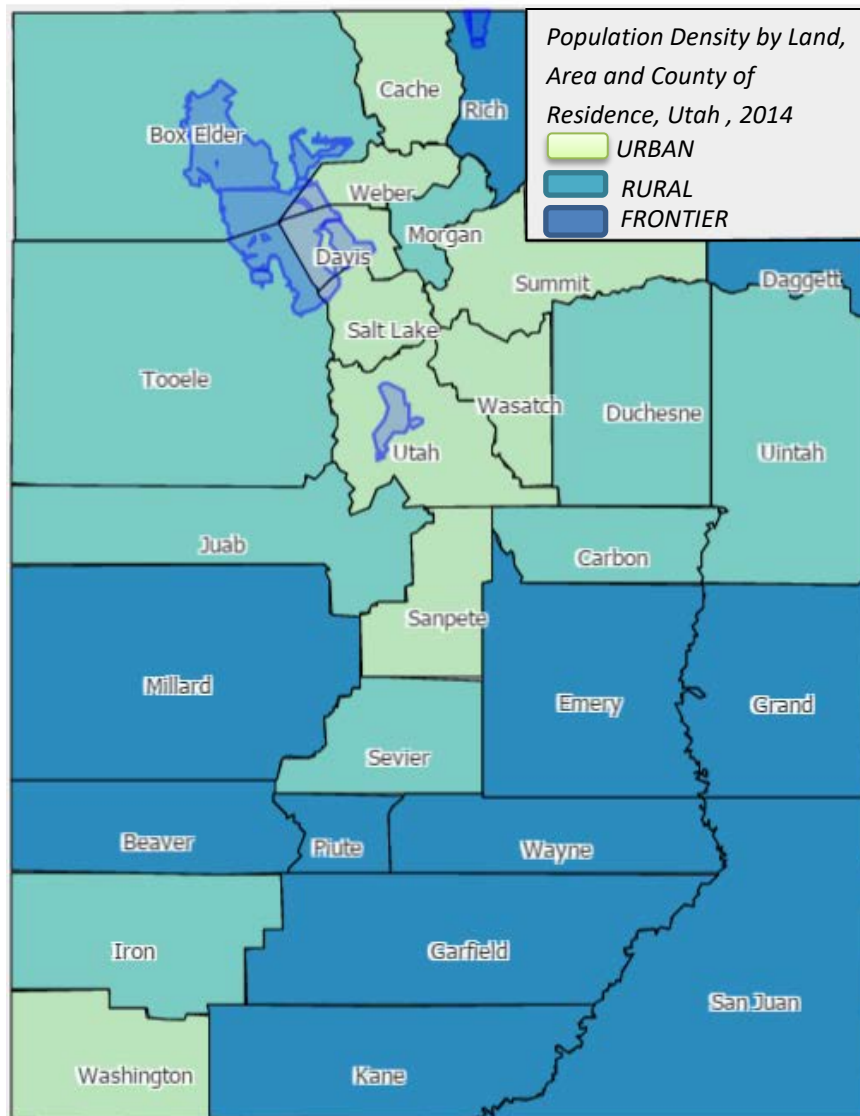
Age and Sex

The table below shows a comparison of the distribution of gender within Utah and the U.S. Utah has a slightly higher proportion of males while the opposite is seen in the U.S. (Table X).

Percent of population by sex, Utah and U.S. 2014		
Sex	**Utah**	**U.S.**
Male	50.3%	49.2%
Female	49.7%	50.8%

The age distribution of Utah residents is slightly younger than that of U.S. residents overall (Figure X).[4] According to the 2010 census, the median age of Utah residents was 29 years old while the median age of U.S. residents was 37 years old. Half of the Utah population is between five and 34 years of age (Figure X).[5]

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[4] *U.S. Census Bureau, Population Division*
[5] *The US Census Bureau, Age & Sex Composition, 2010. For more information, go to*
https://www.census.gov/prod/cen2010/briefs/c2010br-03.pdf

Percentage of Population by Age Group, Utah and U.S., 2014
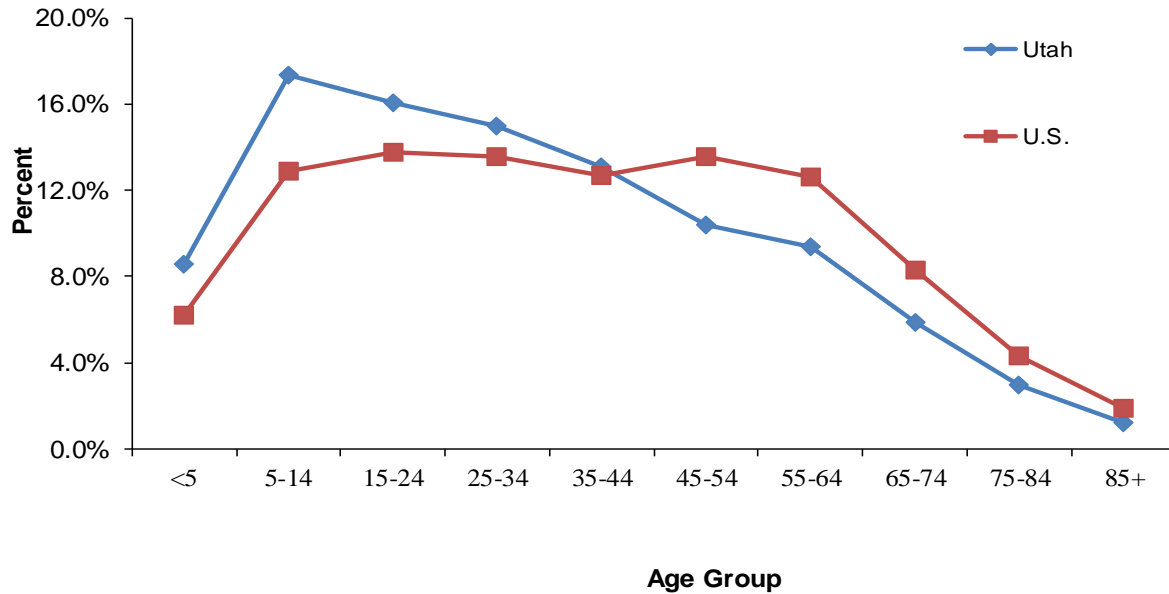
Race and Ethnicity

According to the 2010 census, the majority (86.1%) of Utahns described themselves as White (Figure X).[6] In the U.S., 72.4% of the population described themselves as White (Figure X).[7] When asked about ethnicity, 13% of Utahns described themselves as being from Hispanic or Latino origin, while 87% of Utahns, reportedly, were of non-Hispanic or Latino origin (Figure X).[8]

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[6] *Population Estimates Program, U.S. Bureau of the Census.*
[7] *Population Estimates Program, U.S. Bureau of the Census.*
[8] *Population Estimates Program, U.S. Bureau of the Census.*

Percentage of Population by Race, Utah and U.S. 2014

Legend: ■ Utah ■ U.S.

- White: Utah 91.4%, U.S. 77.4%
- Black or African American: Utah 1.3%, U.S. 13.2%
- American Indian or Alaskan Native: Utah 1.5%, U.S. 1.2%
- Asian: Utah 2.4%, U.S. 5.4%
- Native Hawaiian or other Pacific Islander: Utah 1.0%, U.S. 0.2%
- Two or more races: Utah 2.4%, U.S. 2.5%
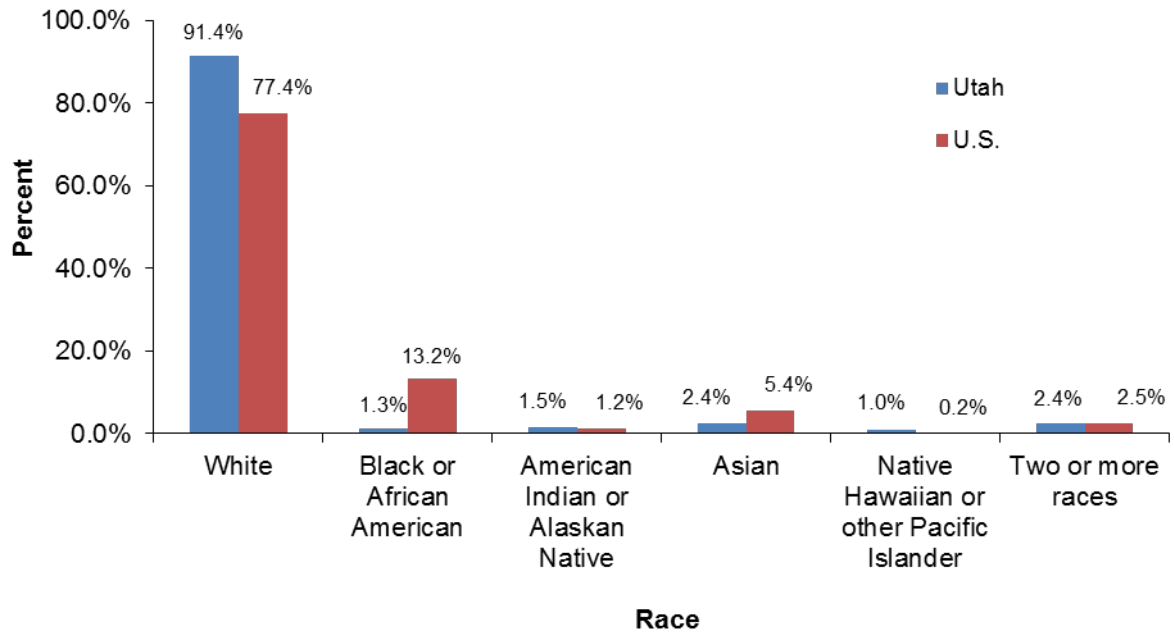
Percentage of Population by Ethnicity, Utah 2014, N=2,942,902

- Hispanic/Latino Origin 13.5%
- Non-Hispanic/Latino Origin 86.5%
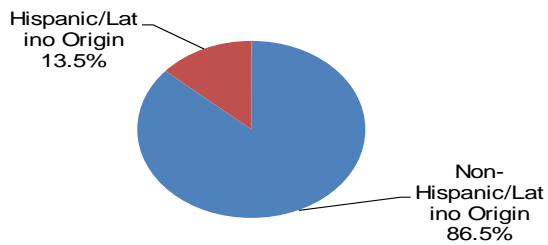
Religion

Utah is known for being one of the most religiously homogeneous states in the U.S. with over half (55.0%) of its adult inhabitants claiming membership in The Church of Jesus Christ of Latter-day Saints (commonly referred to as the Mormon Church).[9]

[9] *"U.S. Religious Landscape Survey 2014", the Pew Forum on Religion & Public Life 2014. Accessed 04 April 2016.*
http://religions.pewforum.org/pdf/report-religious-landscape-study-full.pdf

Ages Birth-12

Child Maltreatment

Overview

Child maltreatment includes child abuse and neglect and according to the CDC is "Any act or series of acts of commission or omission by a parent or other caregiver (e.g., clergy, coach, teacher, etc.) that results in harm, potential for harm, or threat of harm to a child."[10] There are four major types of maltreatment: physical abuse, child neglect, sexual abuse, and emotional abuse.[11] In Utah, domestic violence in the presence of a child or children is also against the law and is considered child maltreatment.

The term Adverse Childhood Experience (ACE) describes the types of abuse, neglect, and household challenges that may have been experienced by individuals under the age of 18. These experiences have been linked to reduced health and well-being later in life. Adverse experiences can include abuse, neglect, parents' divorce, witnessing violence, household substance abuse, household mental illness, household death, household incarceration, and other stressful events. 63% of Utah adults report that they have had at least one adverse childhood experience. [12]

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[10] *http://www.cdc.gov/ViolencePrevention/childmaltreatment/definitions.html accessed 02/28/2011*
[11] *Child Abuse Prevention and Treatment Act. U.S. Code 42 USC 5101 et seq; 42 USC 5116 et seq.*
[12] *Utah Division of Child and Family services Child Maltreatment Factsheet FY 2015*

Percentage of Supported Child Protective Service Cases by Allegation Type, Utah 2015

Allegation type	Percent
Medical Neglect	<1%
Other	5.0%
Non-Supervision	6.0%
Psychological Abuse	7.0%
Neglect or Deprivation of Necessities	13.0%
Domestic Violence	18.0%
Physical Abuse	21.0%
Child Endangerment	27.0%
Sexual Abuse	28.0%
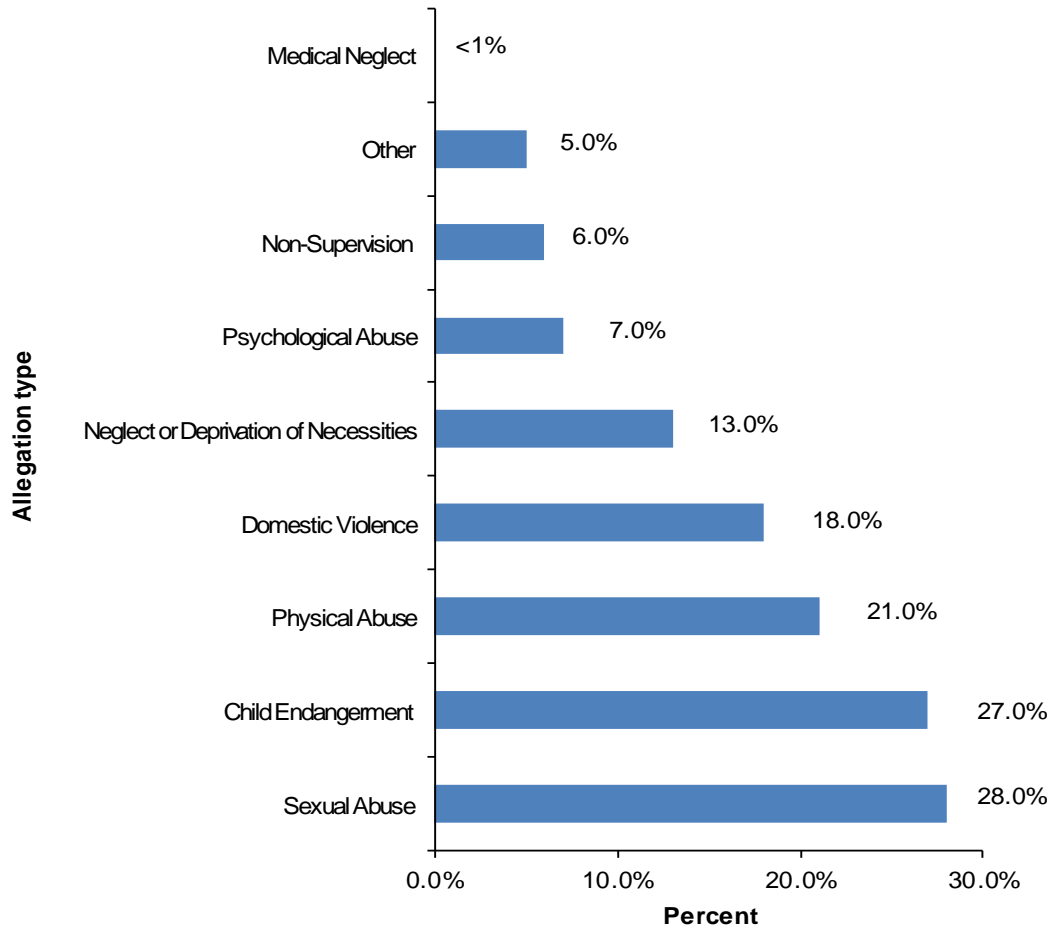
* Note that one case may have more than one supported allegation; therefore, the percentages in the chart above add up to more than 100 percent.

Age and Sex

According to the Utah Department of Child and Family Services in FY15, of the substantiated child maltreatment cases, 54.0% were female and 46.0% were male. Children aged 0-5 comprised 38% of all supported victims (Figure X), and adults aged 18-30 years comprised 39.0% of supported perpetrators (Figure X). Approximately 73.0% of perpetrators were the victim's parents, stepparent, or adoptive parent. [13]

Primary Victim in child abuse cases by age group, Utah 2015

0-5 years
38.0%

6-10 years
27.0%

11-13 years
14.0%

14-17 years
21.0%
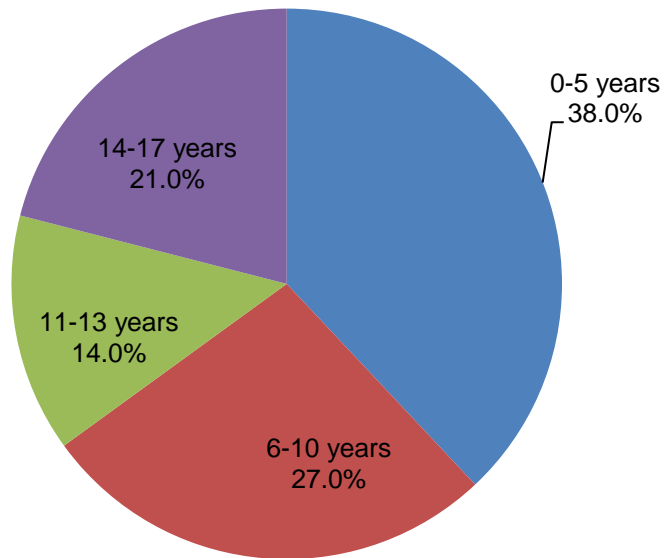
Child abuse perpetrator by Age group, Utah 2015

- 51+ years 5.7%
- 10-17 years 7.6%
- 41-50 years 13.6%
- 18-30 years 39.0%
- 31-40 years 34.1%
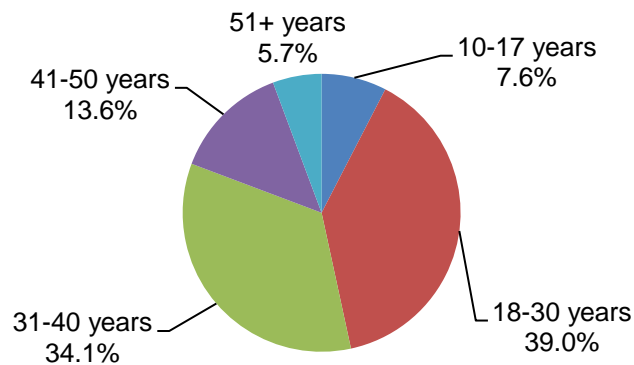
Costs

There is no means available to assess the overall economic costs of child maltreatment. Numerous studies have documented the link between the maltreatment of children and a wide range of medical, emotional, psychological, and behavioral disorders. These problems follow abused children throughout their lives. Regardless of the economic costs associated with child maltreatment, it is impossible to overstate the tragic consequences endured by the children themselves. The costs of such human suffering are incalculable. The total cost of lifetime estimated financial costs associated with a a year of confirmed cases of child maltreatment, is approximately $124 billion[14]

Healthy People 2020 Objectives
- IVP-37 Reduce child maltreatment deaths
- IVP-38 Reduce nonfatal child maltreatment

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[13] *Utah Division of Child and Family Services, 2015. Child maltreatment Factsheet FY15*
[14] *Fang, Xiangming, et al. "The economic burden of child maltreatment in the United States and implications for prevention."* Child abuse & neglect *36.2 (2012): 156-165.*

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

> **Objective 1: By 2021, maintain the Utah Coalition for Protecting Childhood, a statewide child maltreatment prevention coalition and increase and/or enhance participation**

Activities
1. Through 2021, maintain existing partnerships with the Office of Home Visiting, Prevent Child Abuse Utah, the Division of Child and Family Services, nonprofits, public health, schools, healthcare providers, and others and develop new partnerships.
2. Through 2021, maintain existing coalition subcommittee to conduct child maltreatment prevention activities in the areas of policy and systems change, data and evaluation, and community engagement and public awareness.
3. By 2017, convene a minimum of six, bi-monthly Steering Committee meetings to set the vision, common agenda, and develop a strategic plan
4. Through 2021, convene a minimum of six, bi-monthly Backbone Committee meetings each year to implement the activities outlined in the strategic plan
5. Starting in 2016, distribute yearly satisfaction surveys with 100% of coalition members.

> **Objective 3: By 2021, maintain the quality of existing data and enhance child maltreatment and ACE surveillance systems.**

Activities
1. Through 2021, continue including the Adverse Childhood Experience (ACE) module on the Behavioral Risk Factors Surveillance System a minimum of every three years; explore including it every year.
2. By 2021, publish reports on the findings of the 2016 and 2019 ACE surveillance data.
3. By 2018, conduct a statewide survey of partners to identify child maltreatment prevention efforts and resource gaps in each county in Utah.
4. By 2020, develop a list of data needs that are not being addressed by existing data sources.
5. Through 2021, increase capacity of epidemiological and support staff to collect, analyze, interpret, and evaluate child maltreatment data
6. By 2021, work with internal and external partners to increase data sharing and shared measurement of child maltreatment and ACE data.
7. Through 2021, ensure capacity to produce and disseminate data reports.

8. By 2021, integrate ACE health outcomes data into other Bureau of Health Promotions programs.
9. Through 2021, conduct yearly reconciliation of NCANs data.

> **Objective 4: By 2021, enhance the quality of child fatality reviews.**

1. By 2018, input all child fatality cases in Utah into the National Child Death Review database.
2. Through 2021, create an annual report of all UDOH Child Fatality Review Committee (CFRC) recommendations to present to the advisory committee.
3. Through 2021, hold annual CFRC advisory committee meetings to review systems recommendations and identify priority recommendations to act on in the following year.
4. Through 2021, work with systems to implement recommendations.
5. Through 2021, create annual report on the status of CFRC recommendations made the previous year and disseminate to relevant partners.
6. By 2016, work with DCFS and other relevant partners to explore tracking near fatalities.
7. By 2016, get data sharing agreement to give DCFS access to the Child Death Review database.
8. Through 2021, meet with DCFS semi-annually to reconcile data from child fatality reviews.
9. By 2021, increase collaboration between fatality reviews, such as the DCFS child fatality review and the perinatal mortality review.

> **Objective 4: By 2021, increase the education, training, and awareness of child maltreatment and ACEs in Utah using evidence-based programs and best practices.**

Activities
1. By 2021, streamline efforts of evidence-based programs such as the Early Childhood Home Visitation Program, Nurse-Family Partnerships, evidence-based parenting programs and other evidence based child welfare practices.
2. By 2018, secure funding to increase prevention efforts.
3. By 2021, conduct comprehensive evaluation of prevention efforts and create a report.
4. Through 2021, train all Utah Coalition of Protecting Childhood members in ACEs, brain science, resilience, child development, trauma-informed practice, and risk and protective factors for child maltreatment.
5. By 2019, train targeted partners and community members in ACEs and risk and protective factors.
6. By 2018, develop education and awareness objectives for inclusion in the strategic plan.
7. Through 2017, continue serving on the House Bill 286 implementation committee, spearheaded by the Utah State Office of Education.

Objective 5: By 2021, increase policy efforts for the prevention of child maltreatment and ACEs.

Activities
1. Through 2021, maintain a child maltreatment policy subcommittee.
2. By 2021, increase education to policy makers on ACEs, brain science, resilience, child development, trauma-informed practice, and child maltreatment incidence and prevention, including risk and protective factors.
3. By 2018, develop child maltreatment policy objectives for inclusion in the strategic plan.
4. By 2019, identify ideal policies (systems and legislative) that address child maltreatment and ACEs.
5. By 2021, work with partners to implement identified ideal policies.

Implementing Organizations
- Child Fatality Review Committee
- Commission on Criminal and Juvenile Justice
- Prevent Child Abuse Utah
- Primary Children's Medical Center
  - Safe and Healthy Families
- United Way
- Utah Department of Health
  - Violence and Injury Prevention Program
  - Early Childhood Utah Program
- Utah Department of Human Services
  - Division of Child and Family Services
- Other community advocates and nonprofits

Evidence-based Interventions/Best Practices
- Child-Parent Centers (http://www.promisingpractices.net/program.asp?programid=98)
- Nurse-family Partnership (http://www.nursefamilypartnership.org/)
- Triple P (http://www.cdc.gov/violenceprevention/pub/triple_p.html)

Infant Sleep-related Fatalities

Overview

Infant sleep-related deaths include Sudden Infant Death Syndrome (SIDS), SIDS vs. Asphyxia, unintentional injury deaths during sleep, and deaths of undetermined manner in a sleep environment.

Risk factors for infant sleep-related deaths include sharing a sleep surface with another person, sleeping on an adult mattress, bedding material/items in crib or ill-fitting mattresses, sleeping in a position other than on the baby's back, and having mothers who smoked during pregnancy.

Utah had a significantly higher rate of SIDS deaths than the U.S. in 2013 (51.0 per 100,000 infants and 39.7 per 100,000 infants) (Figure X).

Figure X

Rate of SIDS Deaths, U.S. and Utah, Infants, 2013
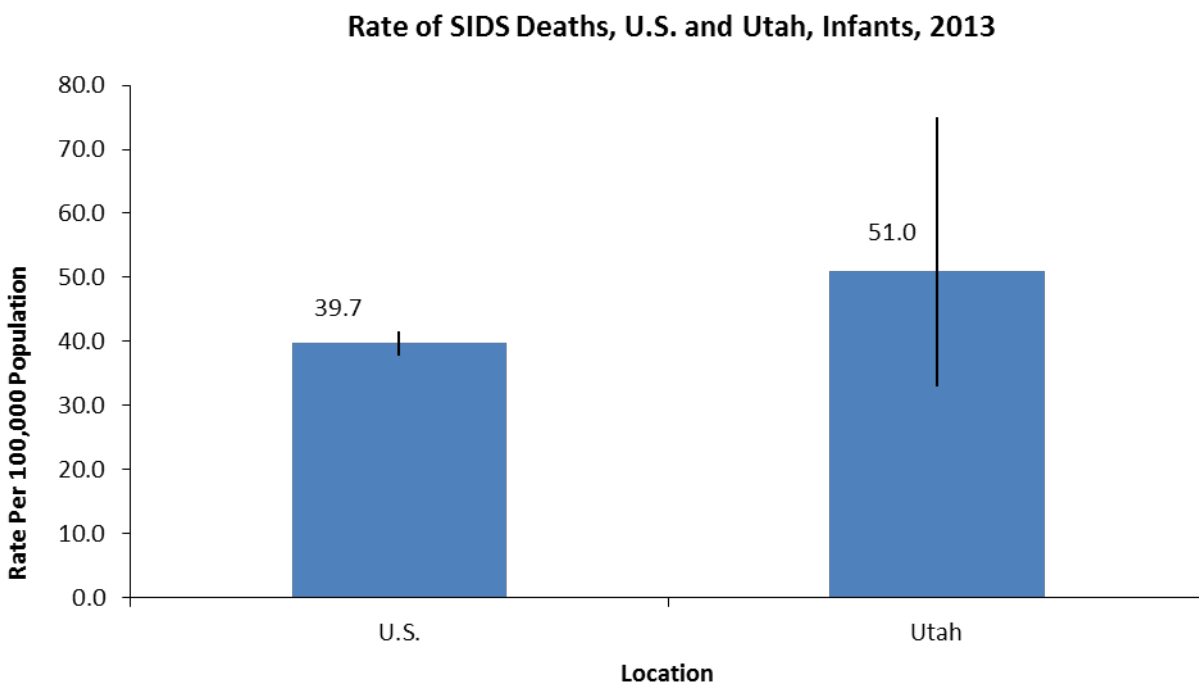
However, from 2010 – 2013, SIDS was the fourth leading cause of death for Utah children in the first year of life. The top five causes of death for infants in Utah were perinatal conditions[15]

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[15] *IBIS Infant Mortality Rate by Major Causes*

(N=461), congenital malformations (N=288), medical conditions (N=106), SIDS (N=100), and unintentional injuries (N=41)[15].

Healthy People 2020 Objectives
- IVP-24   Reduce unintentional suffocation deaths
- MICH-1.8   Reduce deaths from Sudden Infant Death Syndrome (SIDS)
- MICH 1.9   Infant deaths from sudden unexpected infant deaths (includes SIDS, Unknown Cause, Accidental Suffocation, and Strangulation in Bed)

Prevention Strategies
The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By the end of 2016, increase data collection on infant sleep-related deaths in the Child Death Review Surveillance System.

Activities
1. By 2016, develop a list of data needs that are not covered by existing data sources.
2. By 2016, work with Michigan Public Health Institute to add state-added variables to the CDR system.
3. Through 2020, participate in the National Child Death Review System.

Objective 2: By the end of 2017, disseminate information from surveillance data to three agencies.

Activities
1. By 2017, produce an infant sleep-related deaths indicator for the Indicator Based Information System for Public Health (IBIS-PH).
2. Through 2020, update infant sleep fact sheets on an annual basis.
3. Through 2020, disseminate data to at least three partners for use in community assessments, strategic planning, etc.

Objective 3: By the end of 2015, educate 1,000 parents/caregivers about safe infant sleep practices.

Activities
1. By 2017, conduct a survey with at least 100 pediatricians, family practitioners, and other healthcare providers who care for infants (e.g. advanced practice nurses) to determine what information they are giving parents/caregivers on safe sleep.

2. By 2017, partner with the Utah Department of Health Maternal and Infant Health Program to develop and distribute a survey with at least 100 parents/caregivers to determine the prevalence, circumstances, and reasons for co-sleeping with their infant.
3. By 2018, develop educational materials of best practices for safe sleep for healthcare providers to distribute to their patients.
4. By 2018, partner with the Utah Department of Health Child Care Licensing Program to educate child care centers/facilities staff about safe sleep practices.
5. By 2019, evaluate materials with women of childbearing age to determine their effectiveness and whether they are culturally appropriate.
6. By 2020, partner with the Utah Department of Health Baby Your Baby Program, Maternal and Infant Health Program, and Safe Kids Utah to distribute educational materials to at least 1,000 women who are pregnant or of child bearing age.
7. By 2020, provide educational materials on safe infant sleep and sharing sleep surfaces to at least two healthcare provider training programs.

Implementing Organizations
- Child care centers/facilities
- Child Fatality Review Committee
- Primary Children's Medical Center
- Safe Kids Utah
- Utah Chapter of the American Academy of Pediatrics
- Utah Department of Health
  - Baby Your Baby Program
  - Child Care Licensing Program
  - Children with Special Health Care Needs
  - Maternal and Infant Health Program
  - Pregnancy Risk Line
  - Tobacco Prevention and Control Program
  - Violence and Injury Prevention Program
- Utah hospital nurseries and healthcare providers

Evidence-based Interventions/Best Practices
- American Academy of Pediatrics[16] http://www.aap.org/

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[16] *Policy Statement: The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk. Task Force on Sudden Infant Death Syndrome. Pediatrics 2005;116(5):1245-1255; originally published online Nov 1, 2005; DOI 101542/peds.2005-1499.*

Motor Vehicle Crashes

Overview

Motor vehicle crashes[17] (MVC) are the second leading cause of injury death, behind poisoning, for all ages in Utah. Motor vehicle crashes may include occupants in motor vehicles (driver and passengers), motorcyclists, bicyclists, pedestrians, and All Terrain Vehicle/Off Highway Vehicles (ATV/OHV).

Utah's rate of MVC traffic[18] occupants[19] deaths decreased since 2006 (Figure X).
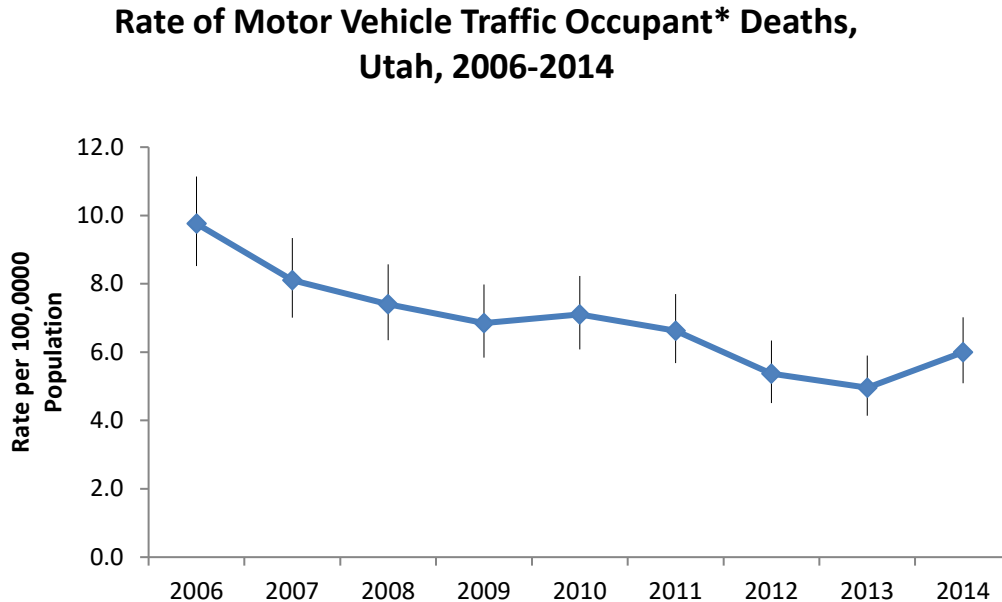
Figure X

Rate of Motor Vehicle Traffic Occupant* Deaths, Utah, 2006-2014

*Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators

However, motorcyclist[20] , bicyclist[21] , pedestrian[22] , and Other motor vehicle[23] deaths have remained fairly consistent during this time (Figure X).

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[17] *Motor Vehicle Crashes include eight indicators on IBIS: 1) MV traffic-occupant injured, 2) MV traffic-motorcyclist injured, 3) MV traffic-pedal cyclist injured, 4) MV traffic-pedestrian injured, 5) MV traffic-other and unspecified, 6) pedal cyclist MV non-traffic and other, 7) pedestrian MV non-traffic and other, and 8) other MV non-traffic and other.*
[18] *MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified.*
[19] *Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators.*
[20] *Motorcyclists include those in the MV traffic-motorcyclist injured indicator.*
[21] *Bicyclists include those in the MV traffic-pedal cyclist injured and pedal cyclist MV non-traffic and other indicators.*

Figure X

Rate Of Other Motor Vehicle Deaths by Type, Utah, 2006-2014

*Due to the small numbers, results should be interpreted with caution.

Since 2006, Utah has had a lower MVC traffic death rate than the U.S. (Figure X).[23]

Figure X

[22] *Pedestrians include those in the MV traffic-pedestrian injured and pedestrian MV non-traffic and other indicators.*
[23] *ATV/OHV deaths include those in other MV non-traffic and other indicator.*
[23] *WISQARS*

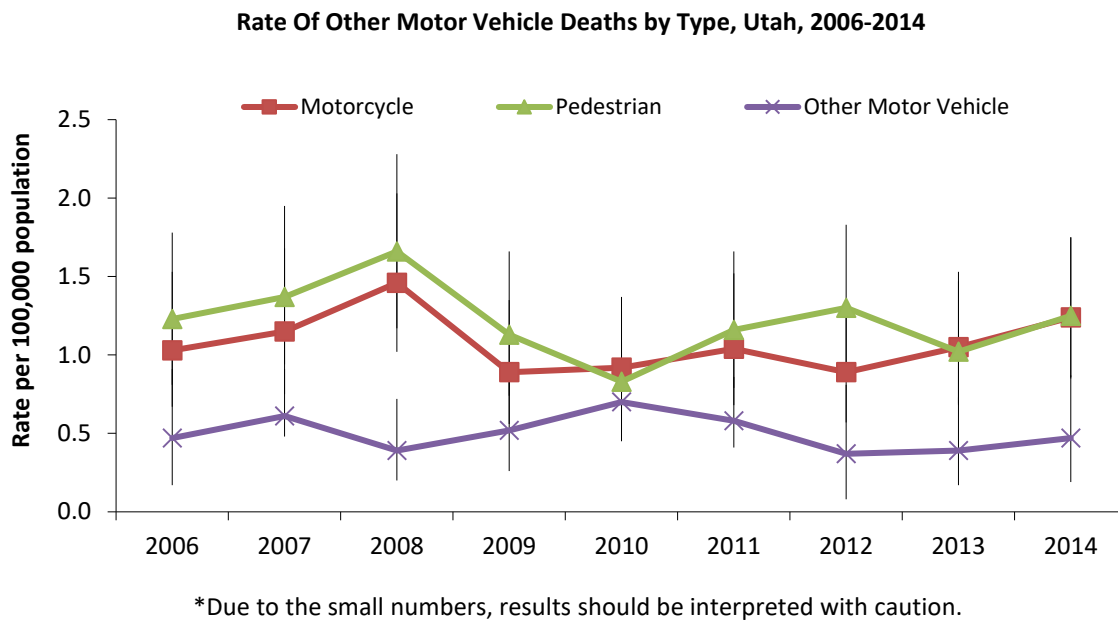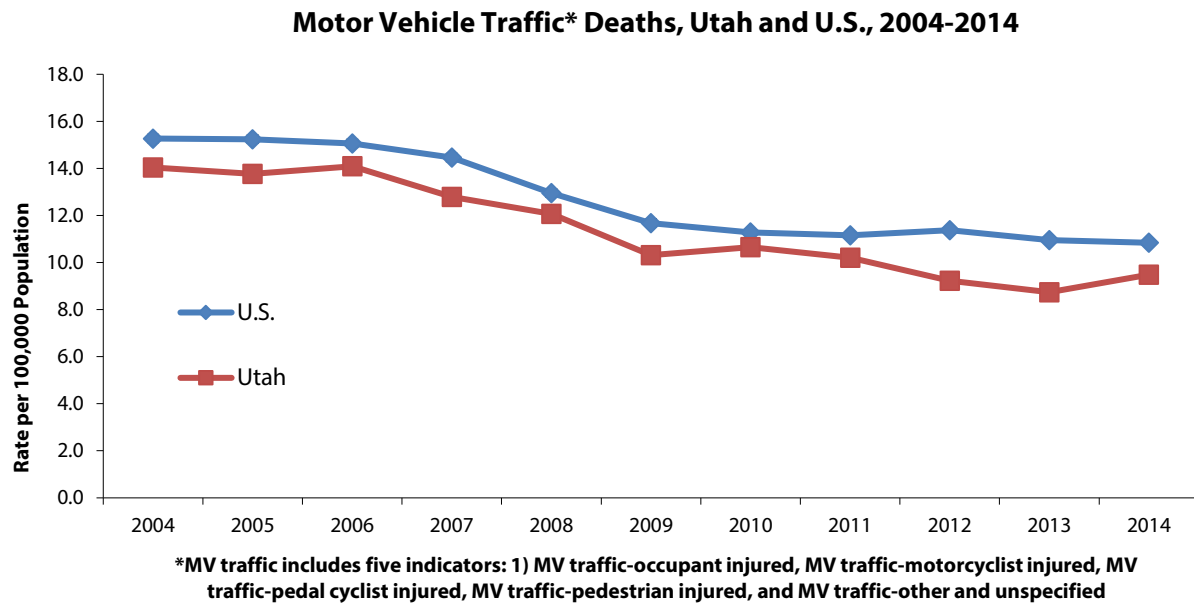## Motor Vehicle Traffic* Deaths, Utah and U.S., 2004-2014

*MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified

In 2014, Utah's MVC traffic death rate for all ages was 8.16 per 100,000 population compared to the U.S. age-adjusted MVC death rate of 10.58 per 100,000 population. [24]

Data, Surveillance and Costs

Geographic

In 2014, Weber-Morgan HD had the highest MVC traffic ED visit rate for all ages at 73 per 10,000 population among local health districts. Tooele HD had the highest MVC traffic hospitalization rate for all ages at 6.01 per 10,000 population while Tricounty HD had the highest MVC traffic death rate for all ages at 25.7 per 100,000 population among local health districts.

Other HDs and small areas with significantly higher and lower MVC rates than the state rate can be found in Appendix X.
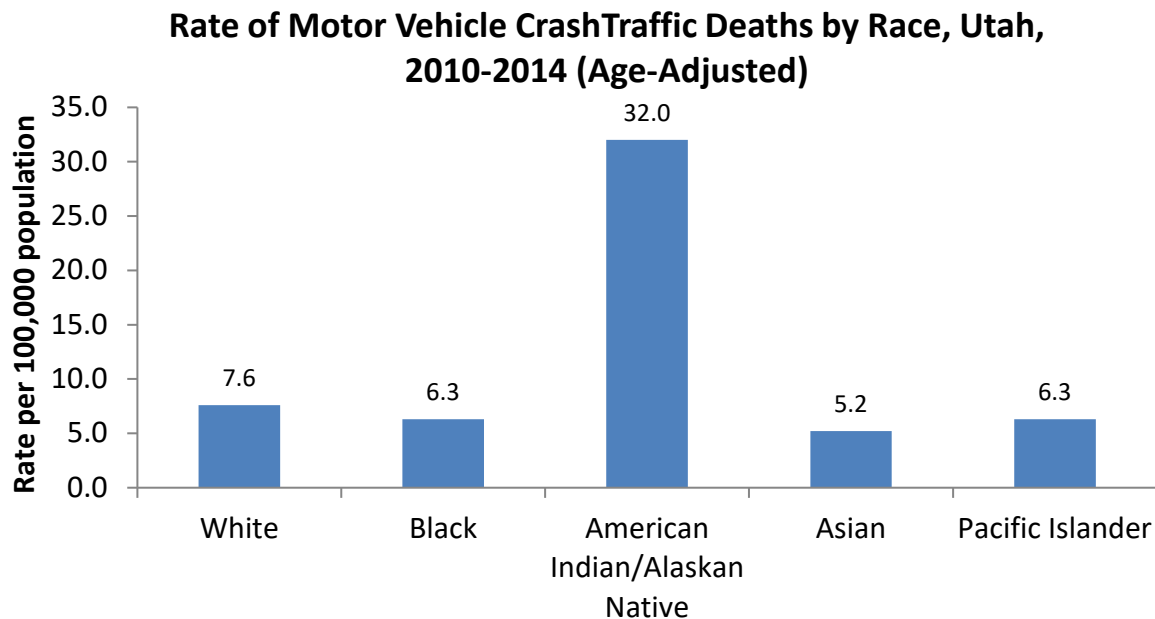
Race and Ethnicity[25]

From 2010-2014, American Indians/Alaskan Natives (32 per 100,000 population) had a higher rate of MVC traffic deaths than White persons (7.6 per 100,000 population) and Black persons

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[24] WISQARS
[25] IBIS

(6.3 per 100,000 population) (Figure X). However, statistical significance could not be calculated because case-level data was not available.

Figure X

Rate of Motor Vehicle CrashTraffic Deaths by Race, Utah, 2010-2014 (Age-Adjusted)

Healthy People 2020 Objectives
- IVP-13   Reduce motor vehicle crash-related deaths
- IVP-14   Reduce nonfatal motor vehicle crash-related injuries
- IVP-15   Increase use of safety belts
- IVP-16   Increase age-appropriate vehicle restraint system use in children
- IVP-17   Increase the number of States and the District of Columbia with "good" graduated driver licensing (GDL) laws
- IVP-18   Reduce pedestrian deaths on public roads
- IVP-19   Reduce nonfatal pedestrian injuries on public roads
- IVP-20   Reduce pedal cyclist deaths on public roads
- IVP-21   Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders
- IVP-22   Increase the proportion of motorcycle operators and passengers using helmets

Prevention Strategies
The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: Develop a pre-driving program/curriculum for preteenagers to better prepare them as drivers.

Activities
1. By 2017, research the development of a preteenager driving program/curriculum to be implemented in Utah schools.
2. By 2017, identified evidence-based driving programs for preteenagers.
3. By the end of 2018, develop plan to implement a preteenager driving program/curriculum in Utah schools.
4. By the end of 2020, implement a preteenager driving program/curriculum in Utah schools.

Objective 2: Increase collaboration with community based organizations and other partners that work with children.

Activities
1. By 2018, further develop and define partnership between Safe Kids and local authorities through Memorandums of Agreement or contracts.
2. By 2018, explore ongoing partnerships with the Utah Auto Association and local car dealers.
3. By 2018, explore ongoing partnership with insurance companies.
4. By 2019, identify grandparent or caregiver programs to promote messaging.
5. By 2018, expand partnership with the Utah State Parks and Recreation Off-highway Vehicle Safety Program to increase access to low-cost OHV/ATV helmets and promote OHV/ATV safety.
6. By 2019, increase collaborative efforts with child-oriented organizations/agencies/groups and child-friendly businesses.

Objective 3: Enact policies/legislation regarding motor vehicle safety.

Activities
1. Through 2020, increase education to elected officials and policy makers on motor vehicle-related trends and challenges through a minimum of two fact sheets, briefings, or other educational activities.
2. By the end of 2020, pass a statewide child bicycle helmet law for ages 17 and under.
3. Through 2020, provide at least two data-driven fact sheets on MVC-related legislation to advocates, Utah Legislature, and other stakeholders.
4. By 2018, complete an evaluation of the Primary Seatbelt Law.
5. By 2019, work with stakeholders to help make the Primary Seatbelt Law permanent.
6. Through 2020, maintain the current child booster seat law.

Objective 4: Continue surveillance of MVC injuries and deaths.

Activities
1. Through 2020, ensure capacity for the production and dissemination of motor vehicle crash-related publications.
2.
3. Through 2020, collaborate with the Utah Highway Safety Office to identify and target surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
4. Through 2020, maintain publicly accessible data query system through the Indicator Based Information System for Public Health (IBIS-PH).
5. Through 2020, leverage existing surveillance systems and data sources to collect motor vehicle crash-related data.
    a.   General crash fatality data FARS/NVDRS
6. Through 2020, develop and update fact sheets and data reports on an annual basis.

Objective 5: Continue Child Passenger Safety efforts statewide.

Activities
1. Continue to develop and improve the Child Passenger Safety technician course.
2. Identify current and future needs and develop a plan to address them.
3. Increase car seat check reporting capacity to get more accurate data on the seats that are being checked statewide.
4. Identify new potential partners to help expand program.
5. Continue education to healthcare professionals through the Save Seats Save Lives program.

Objective 6: Expand the "Don't Drive Stupid" campaign to address children in grades 5-9.

Activities
1. By 2019, conduct an assessment to determine the effectiveness of the "Don't Drive Stupid" messaging for children in grades 5-9.
2. Through 2020, personalize messages to communities based on local stories and local data.

Implementing Organizations
- American Automobile Association (AAA), Utah chapter
- Caring Connections
- Driver education schools and instructors
- Don't Drive Stupid campaign
- Insurance companies

- Law enforcement agencies
- Primary Children's Hospital
- Safe Kids Utah
- Local Health Departments
- Utah Department of Health
  - Violence and Injury Prevention Program
- Utah Department of Public Safety
  - Utah Highway Safety Office
- Utah PTA
- Utah Department of Transportation
- Utah Safety Council
- Utah State Office of Education
- Utah Teen Driving Task Force
- Zero Fatalities Program

Evidence-based Interventions/Best Practices
- Countdown2Drive www.countdown2drive.org
- National Safety Council-designed Alive at 25 curriculum http://aliveat25.us/
- Teendriversource.org http://teendriversource.org/
- Zero Fatalities http://ut.zerofatalities.com/

Childhood Injuries

Overview

Nationally, an estimated 2.2 million children ages 14 and under sustain school-related injuries each year.[26] In the 09-10 school year, Utah had a public school (grades K-12) injury rate of 10.1 injuries per 1,000 students. In Utah,

- 143 elementary school classrooms can be filled with elementary school students who are injured each year,
- An average of 6,200 students are injured each year;
- Over 5,000 school days are missed each year;
- 9-1-1 is called twice every school day; and
- A student is hospitalized every other school day because of a school injury.

Injuries are the most common health problem treated by school health personnel. Schools share in the responsibility of preventing school injuries and providing safe school environments for students.[27] School injuries are most likely to occur on playgrounds, athletic fields, or in gymnasiums.

The Utah Department of Health Violence and Injury Prevention Program (VIPP) identifies school injuries through the Student Injury Reporting System (SIRS). SIRS data has helped schools identify risk factors for student injuries and develop safety guidelines to reduce the physical and financial impact of student injuries on the individual, family, school, and community.

Although participation in the SIRS is voluntary, compliance has been consistent year to year. However, school injuries may be underreported. A goal of the SIRS is to increase the number of reported injuries, which may suggest that school injuries are increasing when actually only the reporting of injuries is increasing.

Data, Surveillance and Costs

Age and Sex

Males have a significantly higher school injury rate compared to females (13.9 and 9.2 per 1,000 students) (Figure X). Females have a higher percentage of school injuries through 5th grade and in 10th and 11th grades. Males have a higher percentage of school injuries in 5th through 9th grades (Figure x). Male and female kindergartners have the lowest percentage of injuries.

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[26] *National SAFE KIDS Campaign (NSKC). School Injury Fact Sheet. Washington (DC): NSKC, 2004.*
[27] *IBIS, School Health Guidelines to Prevent Unintentional Injuries and Violence*

Figure X

Number of student injuries per 1,000 students by sex, Utah, 2006-2007 school year

Rate per 1,000 students

Sex
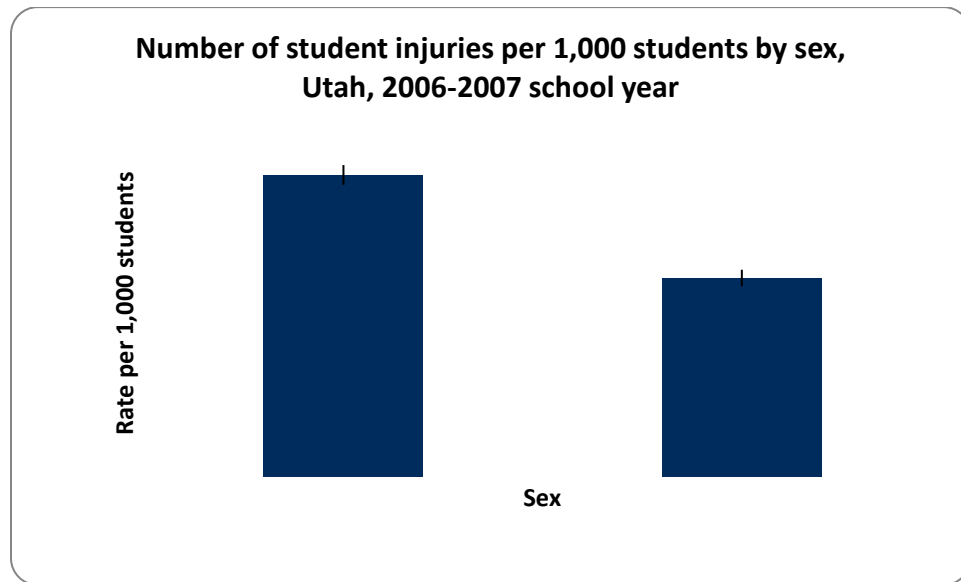
Grades with significantly higher school injury rates than the state rate are 5th, 6th, 7th, 8th, and 9th grades (Figure X). The number of school injuries peaks in 6th grade (10.1%) then declines among high school students.

Figure X

Percentage of Student Injuries by Grade and Sex, Utah, 2007-2008 to 2009-2010 School Years, N=17037

Percent

Grade

K, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th, 11th, 12th

Male
Female

36
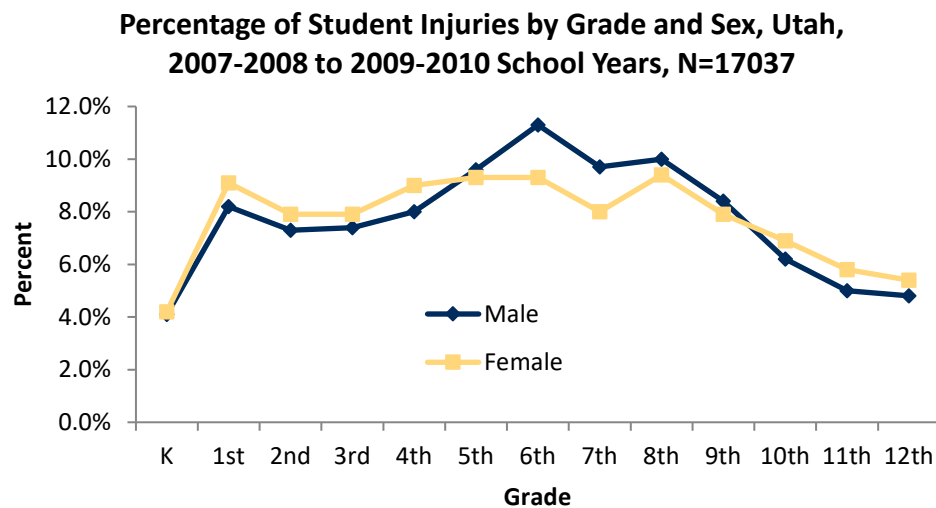
Costs

Nationally, the total annual cost of school-related injuries to children ages 14 and under exceeds $74 billion, which includes medical spending, lost quality of life and future earnings.[28]

Healthy People 2020 Objectives
- **IVP-12** Reduce nonfatal unintentional injuries.
- **IVP-26** Reduce sports and recreation injuries.
- **IVP-27** Increase the proportion of public and private schools that require students to wear appropriate protective gear when engaged in school-sponsored physical activities.

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: Through 2021, encourage school participation in the Student Injury Reporting System and disseminate surveillance data to appropriate stake holders

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Activities
1. Through 2021, ensure sufficient capacity of epidemiological and support staff to collect, analyze, interpret, evaluate and disseminate school injury data.
2. Through 2020, continue to train and encourage school personnel to be more vigilant in reporting injuries that meet criteria to SIRS.
3. By 2017, promote Charter School participation with the SIRS.
4. By 2017, provide online access to the SIR MOA and ensure that all participating school personnel give their consent via electronic signature.
5. Through 2021, produce State and District Injury Reports as well as guidelines for school administrators for using the reports for implementation of injury prevention strategies, and disseminate every 2 years.
6. By 2020, evaluate school district and state reports as to their usefulness in helping school administrators implement injury prevention strategies.
7. By 2020, develop a publicly accessible data query system through the Indicator Based Information System for Public Health (IBIS-PH).
8. Through 2021, explore the opportunity of increasing the capacity of SIR by linking to the national athletic injury database.

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[28] National SAFE KIDS Campaign (NSKC). School Injury Fact Sheet. Washington (DC): NSKC, 2004.

9. Through 2021, ensure ongoing input from Utah State Office of Education, schools, Local Health Departments, and Safe Kids Utah.

Objective 2: By the end of 2021, develop safe schools and recreation centers by developing safety protocols and surveillance practices.

Activities
1. By 2015, distribute and evaluate the use of school injury fact sheets.
2. Through 2015, Risk Management and local health departments will conduct annual safety and hazard inspections, according to state guidelines found at www.rules.utah.gov/publicat/code/r392/r392-200.htm#T7, at 50% of their assigned school playgrounds, gym and sports fields including follow up on corrective actions by using standardized playground safety checklists and equipment guidelines.
3. Through 2021, promote National Playground Safety Week. Through social media
4. Through 2021, provide appropriate safety rules on all school injury publications.
5. Through 2021, provide at least 30 hours of technical assistance to local health departments, schools, Safe Kids Utah, Utah PTA, Utah State Office of Education, Utah School Boards Association, Utah Office of Risk Management, and Utah School Superintendents Association to increase awareness of playground and sports safety and ways to reduce school injuries.
6. Work with recreation centers to help develop concussion protocols and rules for sports with high risk for concussions.
7. Bullying prevention activity

Objective 4: By the end of 2021 increase awareness of injuries that occur in the home and preventative actions that can be taken.

Activities
1. Drowning issues
2. Home safety toolkit

Implementing Organizations
- Local recreation centers
- Safe Kids Utah
- Utah Department of Health
   - Bureau of Health Promotion Schools Workgroup
   - Violence and Injury Prevention Program
- Utah 's Local Health Departments
   - Environmental Health Programs
- Utah Nurses Association
- Utah Office of Risk Management
- Utah PTA

- Utah School Boards Association
- Utah school districts and local schools
- Utah State Office of Education
- Utah School Superintendents Association

Evidence-based Interventions/Best Practices
- CDC Heads Up on Brain Injury http://www.cdc.gov/TraumaticBrainInjury/
- CDC Protect the Ones You Love: Falls http://www.cdc.gov/SafeChild/Falls/index.html
- National Program for Playground Safety http://www.uni.edu/playground/
- U.S. Consumer Product Safety Commission http://www.cpsc.gov/

Ages 13-17

Motor Vehicle Crashes

Overview

Motor vehicle crashes[29] (MVC) are the second leading cause of injury death, behind suicide, for children ages 13-17 in Utah. Motor vehicle crashes may include occupants in motor vehicles (driver and passengers), motorcyclists, bicyclists, pedestrians, and All Terrain Vehicle/Off Highway Vehicles (ATV/OHV).

The Utah rate of MVC traffic[30] occupants[31] deaths decreased since 2006 (Figure X).
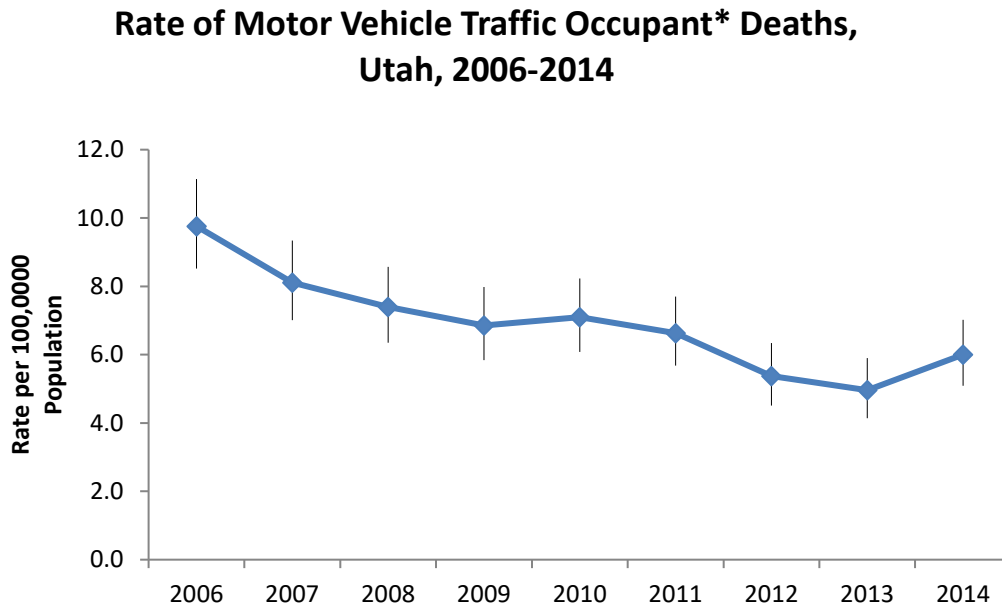
Figure X

Rate of Motor Vehicle Traffic Occupant* Deaths, Utah, 2006-2014

*Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators

However, motorcyclist[32] , bicyclist[33] , pedestrian[34] , and Other motor vehicle[35] deaths have remained fairly consistent during this time (Figure X).

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[29] *Motor Vehicle Crashes include eight indicators on IBIS: 1) MV traffic-occupant injured, 2) MV traffic-motorcyclist injured, 3) MV traffic-pedal cyclist injured, 4) MV traffic-pedestrian injured, 5) MV traffic-other and unspecified, 6) pedal cyclist MV non-traffic and other, 7) pedestrian MV non-traffic and other, and 8) other MV non-traffic and other.*
[30] *MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified.*
[31] *Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators.*
[32] *Motorcyclists include those in the MV traffic-motorcyclist injured indicator.*
[33] *Bicyclists include those in the MV traffic-pedal cyclist injured and pedal cyclist MV non-traffic and other indicators.*

Figure X

Rate Of Other Motor Vehicle Deaths by Type, Utah, 2006-2014

*Due to the small numbers, results should be interpreted with caution.

Since 2004, Utah has had a lower MVC traffic death rate than the U.S. (Figure X).[36]

Figure X

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[34] *Pedestrians include those in the MV traffic-pedestrian injured and pedestrian MV non-traffic and other indicators.*
[35] *ATV/OHV deaths include those in other MV non-traffic and other indicator.*

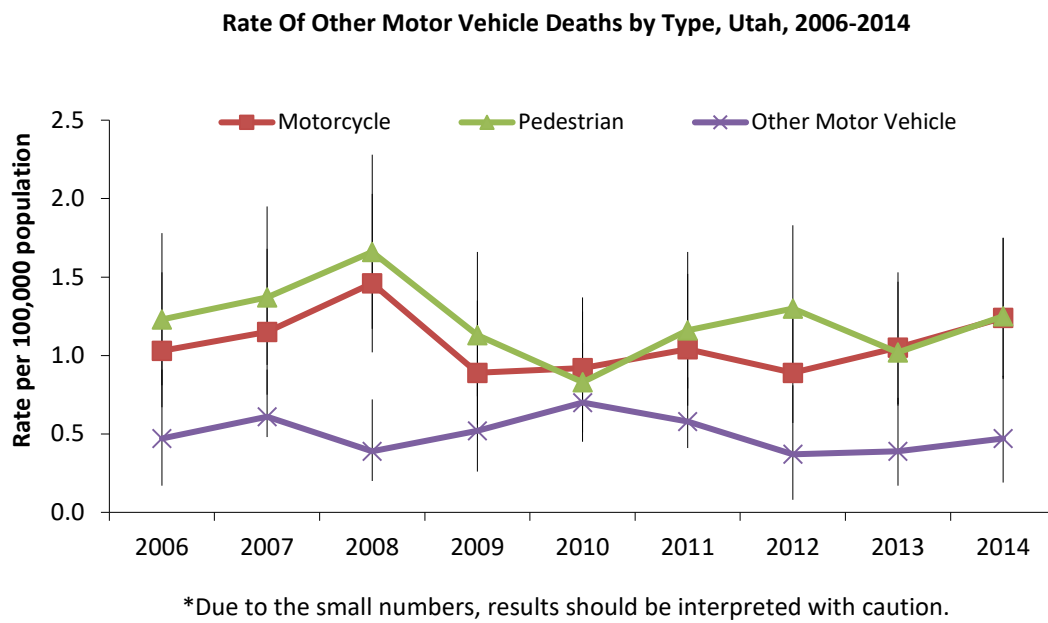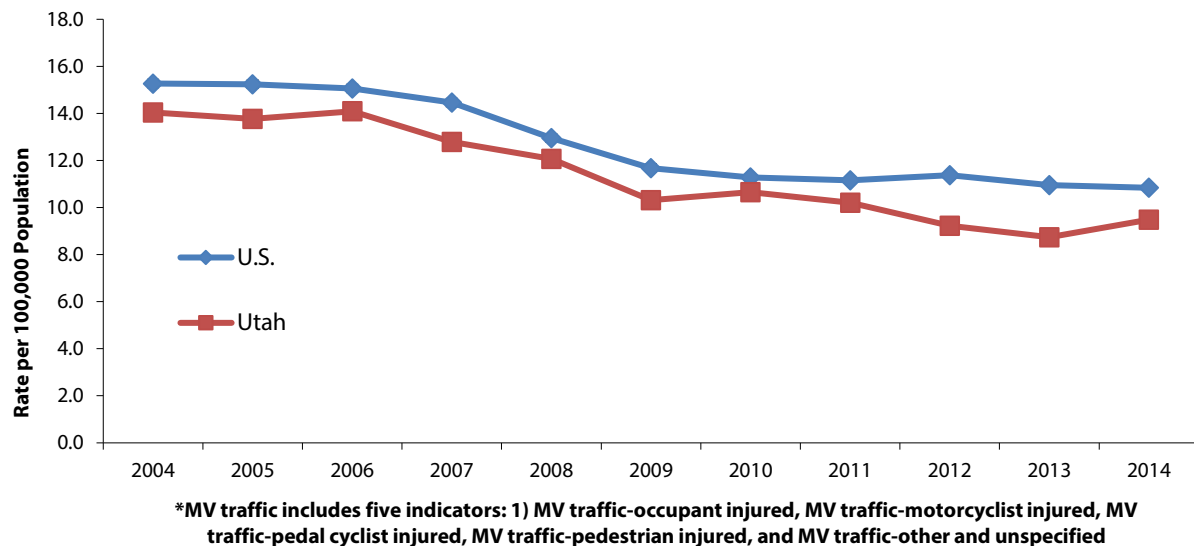## Motor Vehicle Traffic* Deaths, Utah and U.S., 2004-2014

*MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified

In 2014, Utah's MVC traffic death rate for all ages was 8.16 per 100,000 population compared to the U.S. age-adjusted MVC death rate of 10.58 per 100,000 population. [37]

Data, Surveillance and Costs

Geographic
In 2014, Weber-Morgan HD had the highest MVC traffic ED visit rate for all ages at 73 per 10,000 population among local health districts. Tooele HD had the highest MVC traffic hospitalization rate for all ages at 6.01 per 10,000 population while Tricounty HD had the highest MVC traffic death rate for all ages at 25.7 per 100,000 population among local health districts.

Other HDs and small areas with significantly higher and lower MVC rates than the state rate can be found in Appendix X.
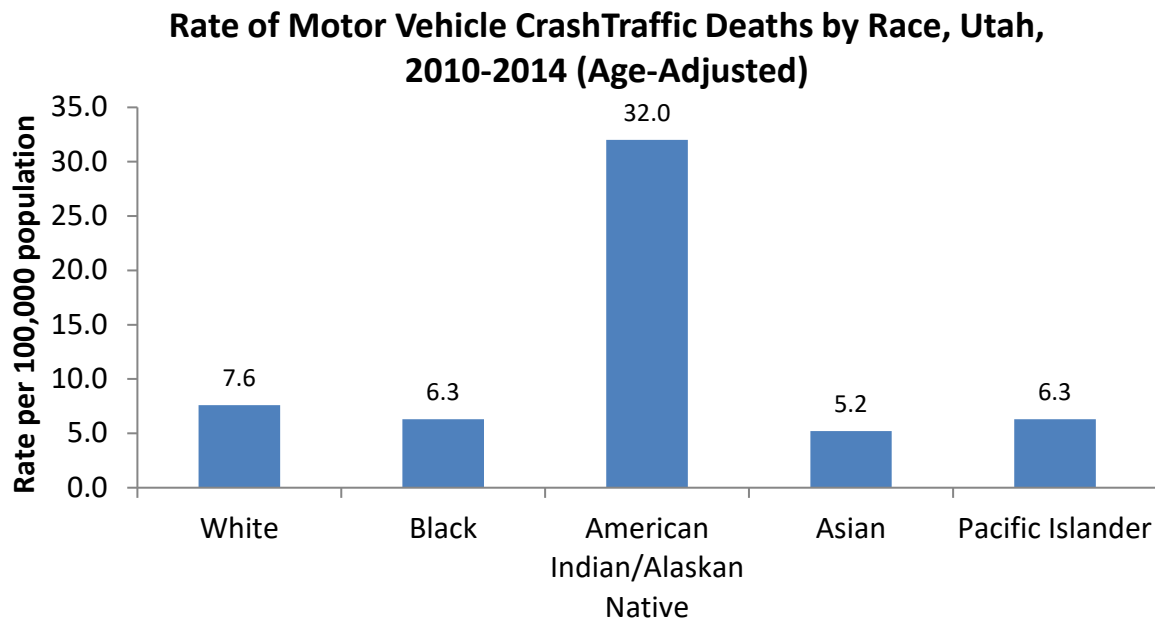
Race and Ethnicity[38]
From 2010-2014, American Indians/Alaskan Natives (32 per 100,000 population) had a higher rate of MVC traffic deaths than White persons (7.6 per 100,000 population) and Black persons

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[36 37] *WISQARS*

[38] *WISQARS, data years 2001-2005*

(6.3 per 100,000 population) (Figure X). However, statistical significance could not be calculated because case-level data was not available.

Figure X

Rate of Motor Vehicle CrashTraffic Deaths by Race, Utah, 2010-2014 (Age-Adjusted)

Healthy People 2020 Objectives
- IVP-13   Reduce motor vehicle crash-related deaths
- IVP-14   Reduce nonfatal motor vehicle crash-related injuries
- IVP-15   Increase use of safety belts
- IVP-16   Increase age-appropriate vehicle restraint system use in children
- IVP-17   Increase the number of States and the District of Columbia with "good" graduated driver licensing (GDL) laws
- IVP-18   Reduce pedestrian deaths on public roads
- IVP-19   Reduce nonfatal pedestrian injuries on public roads
- IVP-20   Reduce pedal cyclist deaths on public roads
- IVP-21   Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders
- IVP-22   Increase the proportion of motorcycle operators and passengers using helmets

Prevention Strategies
The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

> **Objective 1: Continue implementation and evaluation of the "Don't Drive Stupid" program for teens.**

Activities
1. Through 2020, ensure capacity and dedicated staff to implement the "Don't Drive Stupid" campaign and to assist with school-related educational efforts across the state.
2. Through 2020, continue production of the teen memorial booklet annually.
3. Through 2020, provide support, grief counseling resources, and connections to community resources/opportunities to the families who participate in the teen memorial booklet project.
5. Through 2020 disseminate the teen memorial booklet to stakeholders (e.g., driver education instructors, legislators and policymakers, partners, participating families, etc.)
6. Through 2020, continue to brand community education efforts with the "Don't Drive Stupid" theme.
7. By 2017, conduct an evaluation of the Parent Night Program - a component of the "Don't Drive Stupid" program.
8. Through 2020, continue to personalize "Don't Drive Stupid" messages to local schools/communities (i.e. teen fatality Memorial Day event, teen memorial booklet stories, etc.)
9. By 2013, develop a booklet of examples of how families and communities have gotten involved around a teen motor vehicle-related tragedy in their area.
10. By 2014, develop a best practice parent book companion to supplement the "Don't Drive Stupid" educational activities with teens.
11. By end of 2020, develop an internet-based Parent Night Program to reach parents of teens and teen drivers in rural/frontier areas of Utah.

> **Objective 2: Expand the "Don't Drive Stupid" campaign to address children in grades 5-9.**

Activities
1. By 2013, conduct an assessment to determine the effectiveness of the "Don't Drive Stupid" messaging for children in grades 5-9.
2. By 2012, personalize messages to communities based on local stories and local data.
3. By 2014, develop and implement a service learning project for students in grades 7-12 to educate children in grades K-6 about motor vehicle safety.

> **Objective 3: Increase collaboration with community based organizations and other partners that work with teens.**

Activities
1. Through 2020, coordinate efforts through the Utah Teen Driving Task Force.

2. Through 2020, assess and revamp, if needed, Utah's driver education program and driving requirements for new drivers, including, but not limited to, required parent component.
3. By 2018, conduct at least one educational activity on tribal reservations.
4. By 2020, identify, recruit, and maintain at least three additional partners who work with teens (e.g., EmpoweredParents.org, Prevention Dimensions, One Good Reason, etc.).
5. By 2017, increase local health department participation on the Utah Teen Driving Task Force by at least two agencies.
6. Through 2020, increase coordination and support of law enforcement's efforts to reach young drivers (e.g., Utah Highway Patrol's Adopt a High School program).
7. By 2018, further develop and define partnership between Safe Kids and local authorities through Memorandums of Agreement or contracts.
8. By 2020, explore ongoing partnerships with the Utah Auto Association and local car dealers.
9. By 2020, explore ongoing partnership with insurance companies.
10. By 2017, increase collaborative efforts with child-oriented organizations/agencies/groups and child-friendly businesses.

Objective 4: Continue implementation of the "Alive at 25" Program.

Activities
1. Through 2020, maintain current level of staff support to continue implementation of the "Alive at 25" Program.
2. By 2018, increase implementation of the "Alive at 25" Program by 25%.
3. By the end of 2020, evaluate success of the "Alive at 25" Program and disseminate results to stakeholders.

Objective 5: Enact policies/legislation regarding motor vehicle safety.

Activities
1. Through 2020, increase education to elected officials and policy makers on motor vehicle-related trends and challenges through a minimum of two fact sheets, briefings, or other educational activities.
2. Through 2020, provide at least two data-driven fact sheets on MVC-related legislation to advocates, Utah Legislature, and other stakeholders.
3. Through 2020, maintain the current child booster seat law.
4. By 2020, pass legislation banning hands-free use of cell phones while driving for all ages.
5. Through 2020, evaluate and support policies/legislation regarding distracted driving, impaired driving, drowsy driving, and aggressive driving.
6. By the end of 2020, pass a statewide child bicycle helmet law for ages 17 and under.
7. By end of 2020, explore legislation to strengthen and improve Utah's graduated driver's license requirements.

8. By end of 2020, pass legislation requiring a mandatory educational class for teens who receive a ticket because they were not wearing a seat belt.
9. By 2020, explore legislation that would require teens to retake driver education again if they receive a certain number of tickets within a given time frame.
10. By 2018, complete an evaluation of the Primary Seatbelt Law.
11. By 2019, work with stakeholders to help make the Primary Seatbelt Law permanent.
12. Through 2020, continue to enforce handheld cell-phone-use-while-driving ban law.

Objective 6: Continue surveillance of MVC injuries and deaths.

Activities
1. Through 2020, ensure capacity for the production and dissemination of motor vehicle crash-related publications.
2. Through 2020, collaborate with the Utah Highway Safety Office to identify and target surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
3. Through 2020, maintain publicly accessible data query system through the Indicator Based Information System for Public Health (IBIS-PH).
4. Through 2020, leverage existing surveillance systems and data sources to collect motor vehicle crash-related data.
    a. Driving behaviors through BRFSS, SHARP (YRBSS/PNA)
    b. Impaired driving, specifically opioid intoxication in fatal crashes (UTVDRS)
    c. General crash fatality data FARS/NVDRS
5. Through 2020, develop and update fact sheets and data reports on an annual basis.

Implementing Organizations
- American Automobile Association (AAA), Utah chapter
- Caring Connections
- Driver education schools and instructors
- Don't Drive Stupid campaign
- Insurance companies
- Law enforcement agencies
- Primary Children's Medical Center
- Safe Kids Utah
- Utah's 12 Local Health Departments
- Utah Department of Health
    o Violence and Injury Prevention Program
- Utah Department of Public Safety
    o Utah Highway Safety Office
- Utah PTA
- Utah Department of Transportation

- Utah Safety Council
- Utah State Office of Education
- Local school districts
- Utah Teen Driving Task Force
- Zero Fatalities campaign

Evidence-based Interventions/Best Practices
- Countdown2Drive www.countdown2drive.org
- National Safety Council-designed Alive at 25 curriculum http://aliveat25.us/
- Teendriversource.org http://teendriversource.org/
- Zero Fatalities http://ut.zerofatalities.com/

Recommendations: MVC plan should be coordinated across age groups and activities that are age-specific should be developed with input from the content expert.
-add an objective/activity related to outreach and education for tribal populations.

Suicide Attempts & Fatalities

Overview

From 2012-2014, Utah's age adjusted suicide rate was 20.8 per 100,000 persons. All suicide attempts should be taken seriously. Those who survive suicide attempts are often seriously injured and need medical care. Many have depression and other mental health problems. Most people feel uncomfortable talking about suicide. Victims are frequently blamed and families stigmatized. Friends, families, and communities may feel shock, anger, guilt, and depression and are usually left devastated.[12]

In 2014, suicide was the leading cause of death for Utahns ages 10 to 17 and the overall eight leading cause of death for Utahns ages 10+. Completed suicides are only part of the problem. More people are hospitalized or treated in an emergency room for suicide attempts than are fatally injured. In 2013, 13 Utahns were treated for self-inflicted injuries every day (3,181 emergency department visits and 1,508 hospitalizations).

Data, Surveillance and Costs

Age and Sex

When broken down by age group, 15-24 year old females (37.2 per 10,000 population) and males (22.6 per 10,000 population) had the highest ED visit rates for suicide attempts among age groups (Figure X). For hospitalizations for suicide attempts, 45-54 year old females (11.0 per 10,000 population) and 25-34 year old males (6.74 per 10,000 population) had the highest rates among age groups (Figure X). Fifteen- to 17-year-olds did not have significantly higher suicide deaths when compared to other age groups.

Figure X

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[39]*Centers for Disease Control and Prevention.* Understanding Suicide Fact Sheet 2006. *National Center for Injury Prevention and Control.*
IBIS Health Indicator Report, Suicide.

Rate Of Self Inflicted Injury Emergency Department Visits By Age Group and Sex, Utah, 2010-2013
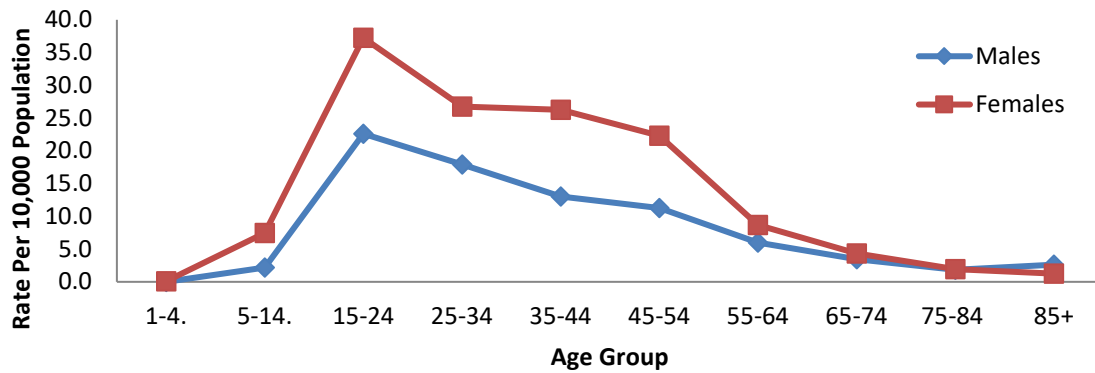

Figure X

According to the Youth Risk Behavior Survey, females are more likely to report feeling sad or hopeless compared to males (32.4 percent and 21.7 percent). In addition, females are more likely to make a suicide plan compared to males (14.9 percent and 10.7 percent) (Figure X).

Figure X

Rate of Self Inflicted Injury Hospitalizations By Age Group and Gender, Utah, 2010-2013
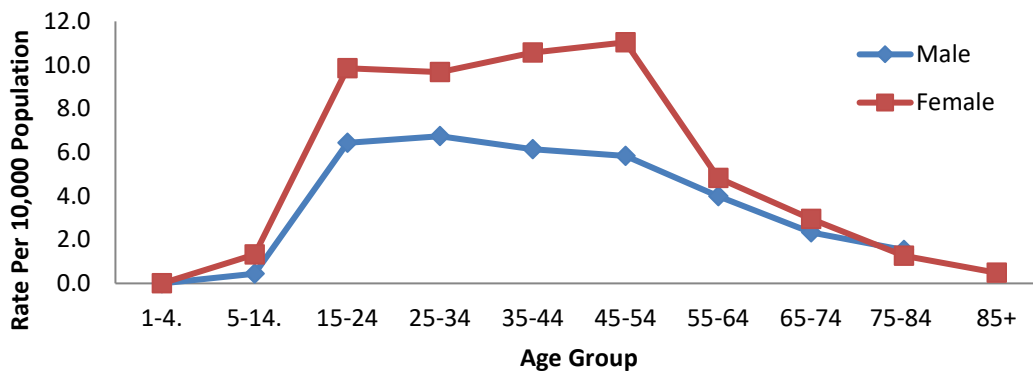
Percentage Of Reported Suicide Behaviors Of High School Students During The Past Year By Sex, Utah, 2009-2013
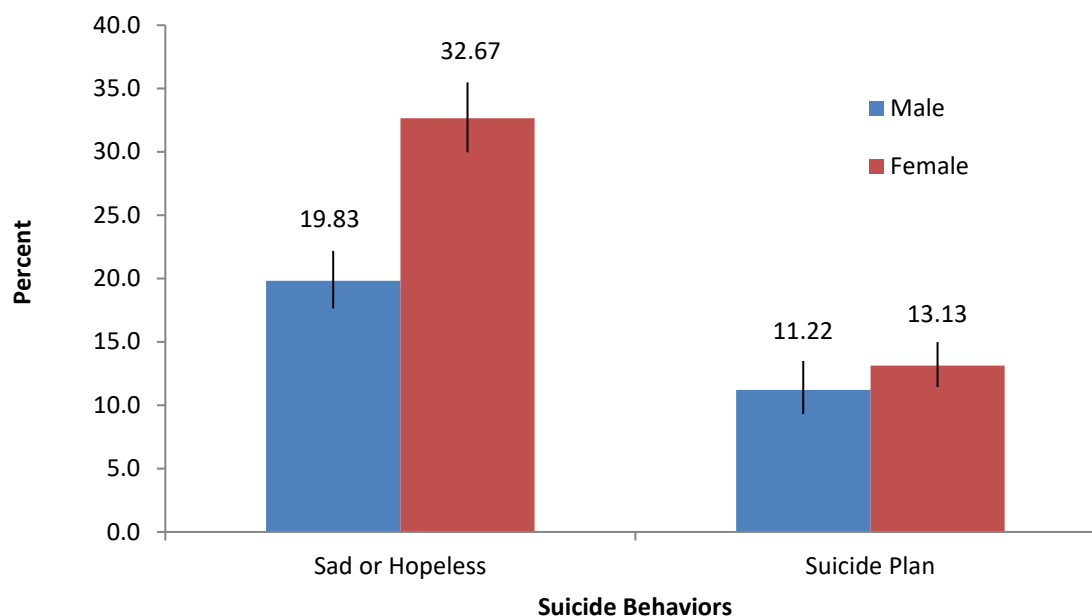
Method of Suicide Attempts

The most common method of injury for suicide attempts for 15-17 years olds was poisoning followed by cut/pierce for both males and females.

Healthy People 2020 Objectives

- **IVP-41**   Reduce nonfatal intentional self-harm injuries
- **ECBP-2**   Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity
- **MHMD-1**   Reduce the suicide rate
- **MHMD-2**   Reduce suicide attempts by adolescents
- IVP-30 Decrease firearm related death
- **IVP-43 – surveillance of violent death**

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on

implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: Through 2020, continue to evaluate existing surveillance systems to adequately monitor and measure suicide and suicide attempts in Utah.

Activities
1. By 2020, continue to work with existing partners and identify 2 additional users of information, assess their needs, and prioritize according to the results of the assessment.
2. Through 2020, continue to evaluate the Utah Violent Death Reporting System, National Child Death Review Database, Prevention Needs Assessment, and the Youth Risk Behavior Survey for their usefulness in monitoring suicide, suicide attempts, suicide ideation, utilization of mental health and substance abuse services, and risk and protective factors for suicide in Utah.
3. By 2018, develop a list of at least two data needs that are not covered by existing data sources.
4. By 2020, add at least two suicide components to existing data collection systems to gather more complete information about populations at risk for suicide, to screen for distress and dysfunction associated with mental illness, and to close gaps in suicide data collection.
5. By 2020, collaborate with partners such as Law Enforcement and the LGBT Committee of the Utah Suicide Prevention Coalition to determine and implement methods to collect, analyze, and interpret more comprehensive data relating to LGBT risk factors, suicide attempts, and death rates in Utah.
6. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate suicide data.
7. By 2020, organize and implement at least one Suicide Fatality Review Committee involving key partners, and regularly share recommendations from the committee with agencies in Utah.
8. By 2020, evaluate Parent Seminars on Youth Protection for feasibility, attendance, and effectiveness, and make recommendations for improvement if necessary.
9. By 2020, develop a Utah suicide prevention research agenda with comprehensive input from multiple stakeholders; then carry out at least one suicide prevention research/evaluation project and disseminate the results.
10. By 2020, identify ways to increase the tracking and coordination of statewide efforts in suicide prevention. By 2020, compile a summary report on progress made regarding the Utah Suicide Prevention Plan.

Objective 2: By the end of 2015, information from surveillance data will be disseminated to appropriate stakeholders.

Activities

1. Through 2020, continue to evaluate suicide data publications as to their usefulness in helping school administrators, local health districts, and community based organizations implement suicide prevention strategies.
2. Through 2020, ensure staff capacity for the production and dissemination of suicide data publications.
3. Through 2020, identify and target surveillance data for at least five specific audiences (e.g., policymakers, schools, local health departments, etc.).
4. Through 2020, improve the availability and accessibility of surveillance data for specific audiences (e.g., policymakers, schools, local health departments, etc.)
5. Through 2020, disseminate at least three youth suicide fact sheets.

6. Through 2020, support, and disseminate lessons learned from the Utah Youth Suicide Study.

Objective 3: By the end of 2020, more than half of Utah high schools will have resource information for students and their parents on the prevention of suicide and the availability/accessibility of mental health services.

Activities

1. By 2020, continue to promote efforts to reduce access to lethal means and methods of self-harm (including firearms, drugs, and poisons) through distribution of at least 5,000 firearm locks and brochures and through promoting at least 10 messages relating to means restriction.
2. Through 2020, continue to support at least 2 existing conferences that specifically address youth suicide; and promote/support opportunities for 2 additional Utah conferences to address evidence-based youth suicide prevention, intervention, and postvention strategies.
3. Through 2020, continue to support and expand implementation of best practice suicide prevention and postvention programs being offered throughout the state, such as QPR, safeTALK, Mental Health First Aid, ASIST, Signs of Suicide, More Than Sad and other programs created or supported by AFSP, Connect Suicide Postvention, etc., to reach at least 10,000 more Utahans by 2020.
4. By 2020, identify and increase implementation of 2 universal, primary prevention strategies for suicide prevention, that focus on resiliency, social support and connectedness, problem-solving skills, and other protective factors, such as the Good Behavior Game or the Seattle Social Development Project.
5. Through 2020, provide at least 3 evidence-based training and tools to behavioral health providers to increase their ability to effectively assess suicide risk, implement appropriate triage, counsel on reducing access to lethal means, engage the client in safety planning, and provide ongoing trauma-informed treatment in a manner that promotes healing and recovery.

6. Through 2020, continue to support and train schools in offering both universal and selective suicide prevention initiatives, and increase the number of these initiatives by 10%, as well as the quality and fidelity of these initiatives.
7. Through 2020, five implementing agencies will provide adequate staffing and resources, including budget, facilities, staff development, and time to implement suicide prevention programs that effect youth.
8. Through 2020, continue to seek out additional funding and resources to implement suicide prevention activities at all levels by applying for at least three grants that would benefit the entire state.
9. Through 2020, define five areas of focus for the role of public health in suicide prevention and increase the number of public health partners that are active in suicide prevention activities by 10%.
10. Through 2020, continue statewide collaboration to successfully implement at least 80% of the activities and recommendations of the Utah Suicide Prevention Plan.
11. Through 2020, continue to promote at least 5 suicide public awareness events sponsored by organizations such as NAMI Utah, Utah Chapter of the Mental Health Association, and the American Foundation for Suicide Prevention.
12. By 2020, identify at least 2 systems and agencies that can increase evaluation of the effectiveness and efficiency of the suicide prevention programs and interventions that are available in Utah, and complete at least 2 evaluation projects.
13. By 2012, implement policy in at least three school districts that designates a person with responsibility for coordinating safety activities at school and promoting a school climate that demonstrates respect, support, and caring that does not tolerate harassment or bullying.
14. Through 2020, 50% of schools will develop and implement written school policies (regarding substance abuse, bullying, violence, suicide crises or interventions, suicide postvention, etc.) in addition to disciplinary policies that are implemented consistently.
15. Through 2020, increase the implementation of suicide prevention curricula for youth that are grounded in theory and/or have scientific evidence of effectiveness, to 50% of school districts.
16. Through 2020, increase staffing and resources, including budget, facilities, staff development, and time to implement suicide prevention curricula in at 90% of all schools.
17. Through 2020, increase access to two youth suicide prevention programs and two mental health or suicide prevention resources in rural and frontier areas of the state that target resource and prevention gaps as identified by local coalitions and agencies.

> **Objective 4: By the end of 2020, increase partnerships between school and community-based organizations to provide suicide prevention resources and services, and implement at least two trainings /materials for identified groups and agencies that address suicide risk factors, treatment for suicidal thoughts, and reporting on suicides.**

Activities

1. By 2020, update existing "pocket card" for reporting on violent deaths. Disseminate pocket card and train at least 50 Utah investigators and medical examiners in comprehensive interviewing techniques and reporting needs in order to improve quality of data gathered for violent deaths and suicides.
2. By 2020, define minimum course objectives addressing suicide risk and protective factors for health care provider and counseling training/graduate programs; and share with at least 5 relevant agencies.
3. Through 2020, continue to educate, support, and involve family members regarding risk and protective factors for suicide, warning signs of suicide, and resources, using at least 20 research-informed media messages.
4. Through 2020, train 5 additional local media representatives to promote accurate, responsible, and hopeful representation of suicidal behaviors, mental illness, and related issues in compliance with national reporting guidelines and Connect Suicide Postvention guidelines Increase the percentage of messages that provide positive narratives about resilience, recovery, treatment, and suicide prevention.
5. Through 2020, train at least 20 additional educational staff, healthcare providers, faith-based organizations, call centers, juvenile justice system professionals, youth-serving social service agencies, and law enforcement officers on identifying and responding to a youth in mental health crisis and/or at risk for suicide. Apply for and provide Continuing Education Units to at least 2 classes of professionals to incentivize professional development regarding suicide prevention topics.
6. Through 2020, continue to support all existing services to survivors of suicide loss, identify and increase at least one resource in rural areas for survivors of suicide loss, and investigate ways to increase outreach to families and youth after a suicide.
7. By 2020, pilot and evaluate at least one support group for suicide attempt survivors in Utah.
8. Through 2020, provide resources such as counseling on reducing access to lethal means, safety planning, and coping skills to teenagers who have attempted suicide through school counselors, emergency rooms, and behavioral health providers.
9. By 2020, investigate and pilot 2 evidence-based ways to provide support and care to clinicians, first responders, and medical professionals when a patient under their care dies by suicide.
10. Through 2020, continue to coordinate school-based counseling, psychological, social, and health services to meet the physical, mental, emotional, and social health needs of teenagers in each school district in Utah.

Objective 5: By the end of 2020, access to mental health and substance abuse services will increase by 10%.

Activities
1. By 2020, implement guidelines for mental health assessment and treatment for suicidal individuals from adult and juvenile incarcerated populations in at least 5 facilities.

2. Through 2020, assess access to mental health care, and improve access to mental health care for uninsured and non-Medicaid youth population by ensuring that at least 50% of this population has access to mental health and psychiatric services.
3. Through 2020, provide referrals and resources for mental health services to the community by updating the Suicide Prevention Coalition's and Utah Department of Health's websites annually and releasing at least 50 media messages or print materials per year to promote resources (statewide and by county or small area) .
4. By 2020, collect current information for mental health and crisis services in each county in Utah and annually update this resource list on the Utah Suicide Prevention Coalition and Utah Department of Health websites.
5. By 2020, distribute the policies and procedures of the UNI crisis response model to all local mental health authorities in Utah to provide them with strategies to increase the quality, capacity, and mobility of their 24-hour crisis care.
6. By 2020, develop and disseminate a protocol/guide based on the UNI Receiving Center and Wellness Recovery Center, to creating crisis and recovery centers as an alternative to Emergency Department care when appropriate, or as a residential level of care that facilitates return to community outpatient care (Objective 8.8 in the National Strategy).
7. Through 2020, conduct a literature review to create a best practice protocol for continuity of care, and provide training and information to at least 15 health and behavioral health agencies.
8. Through 2020, assess how many healthcare providers are currently engaged in the Zero Suicide Initiative and educate providers about the benefits and resources that the initiative provides, to improve the policies and infrastructure of the healthcare and behavioral health systems at all stages of suicide prevention and intervention, and highlight successful systems and programs.
9. Educate physicians on suicide risk assessment and increase the number of health systems using evidence based screening tools for depression and suicide by one.

Implementing Organizations
1. Local junior high and high schools
2. National Alliance on Mental Illness - Utah
3. Utah Department of Health
   o Bureau of Maternal and Child Health
   o Violence and Injury Prevention Program
4. Utah Department of Human Services
   o Division of Substance Abuse and Mental Health
5. Utah's local health departments
6. Utah PTA
7. Utah School Boards of Association
8. Utah School Superintendents Association
9. Utah State Office of Education

Evidence-based Interventions/Best Practices

- CARE (Care, Assess, Respond, Empower) http://www.reconnectingyouth.com
- CAST (Coping and Support Training) http://www.reconnectingyouth.com/cast
- Hope for Tomorrow program http://www.namiut.org/find-local-support/free-education/hope-for-tomorrow
- Lifelines Curriculum http://www.hazelden.org/web/public/lifelines.page, http://www.state.me.us/suicide
- Reconnecting Youth: A Peer Group Approach to Building Life Skills http://www.reconnectingyouth.com
- SOS Signs of Suicide http://www.mentalhealthscreening.org/highschool
- TeenScreen http://www.teenscreen.org

Recommendations: include activities/objectives related to model policy for suicide prevention in school.
-Any sort of screening/referral language related to health care providers/mental health counselors
-Suicide fatality reviews/child fatality reviews?
-Treatment objectives/activities?
QPR training or education for educators and possibly family members of children with diagnosed mental health needs or hx of suicidal ideation?

Youth Violence

Overview

Youth violence refers to harmful behaviors that can start early and continue into young adulthood. This section is meant to encompass a variety of behaviors related to interpersonal violence in adolescence. Interpersonal violence describes the intentional use of force or power, threatened or actual, against another person or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation. Particular behaviors highlighted in this section are dating violence and bullying.

Dating violence is controlling, abusive, and aggressive behavior in a romantic relationship. It can happen in any relationship and includes verbal, emotional, physical, and/or sexual abuse. Dating violence is not a one-time incident but occurs again and again. It is not the same as having disagreements. In a violent dating relationship, one person is afraid or intimidated by the other person.

Bullying is any unwanted aggressive behavior(s) by another youth or group of youths (who are not siblings or current dating partners), involving an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated. Bullying may inflict harm or distress on the targeted youth, including physical, psychological, social, or educational harm. Bullying behaviors can occur in-person or through technology –this is known as electronic aggression or "cyber-bullying", and it occurs via e-mail, chat rooms, instant message, websites, text messages, or social media.

Other behaviors that are targeted for prevention under this section include fighting, weapon use, and gang violence.

Nationally, one in three high school students have been or will be involved in an abusive relationship. In 2011, 11.8% of Utah high school students reported that they have been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend [40](Figure X). However, there were no statistically significant differences between 2007-2011.

Figure X

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[40] *2011 Utah Youth Risk Behavior Survey.*

Percentage Of High School Students Who Report Being Hit, Slapped, Or Physically Hurt On Purpose By Their Boyfriend Or Girlfriend By Year, Utah, 2007, 2009, 2011
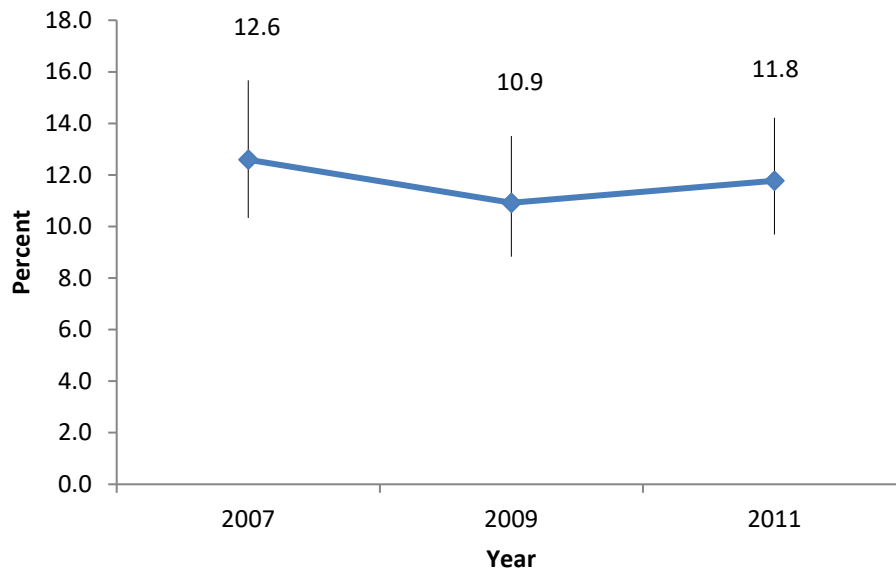
Data, Surveillance and Costs

Age and Sex

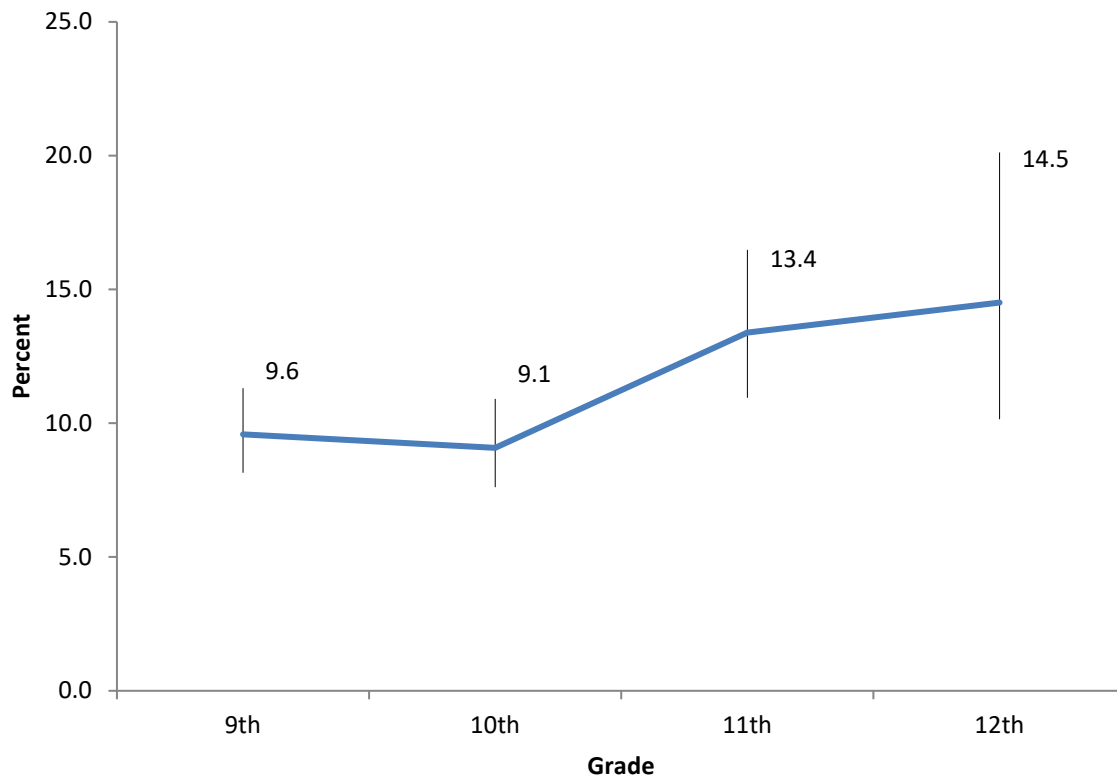Eleven percent of high school males reported they have been hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend compared to 8.9% of females, although this difference was not statistically significant. However, 12th graders (14.5%) were significantly more likely to report dating violence compared to 9th graders (9.6%) (Figure X). [41]

Figure X

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[41] *Utah Youth Risk Behavior Survey.*

Percentage Of High School Students Who Report Being Hit, Slapped, Or Physically Hurt On Purpose By Their Boyfriend Or Girlfriend By Grade, Utah, 2007, 2009, 2011

Race and Ethnicity

Non-White/non-Hispanic high school students (14.7%) report a higher percentage of being hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend compared to White/non-Hispanic (9.4%) and Hispanic high school students (9.5 percent), [42] however, this difference was not significant.

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is a surveillance project that collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. According to 2010-2013 Utah PRAMS data, pregnant women who were less than 17 years old reported the highest prevalence of physical abuse during pregnancy (9.81%)[43].

Healthy People 2020 Objectives
- **IVP-34** Reduce physical fighting among adolescents

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[42] [43]*Utah Youth Risk Behavior Survey.*

- **IVP-39**   Reduce violence by current or former intimate partners
- **IVP-40**   Reduce sexual violence
- **ECBP-2**   Increase the proportion of elementary, middle, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol or other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity
- **ECBP-7**   Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity)
- **IVP-33: decrease physical assaults**
- **IVP-35: decrease bullying among adolescents**
- **IVP35: decrease weapon-carrying on school property**
- **IVP42: decrease children's exposure to violence**

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By the end of 2020, an existing surveillance system will be improved to adequately monitor and measure youth violence in Utah, particularly dating violence and bullying.

Activities
1. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate dating violence data.
2. Through 2020, evaluate and improve the use and quality of existing surveillance systems that collect data related to dating and youth violence.
3. By 2017/18, identify primary users of dating violence information, assess their needs, and prioritize according to the results of the assessment.
4. By 2018, develop a list of youth violence data needs that are not covered by existing data sources.
5. By 2013, conduct a statewide assessment of youth violence prevention resources, interventions, training programs, agencies with an interest in youth violence prevention, etc.
6. By 2017, explore opportunities to add youth violence components, including assessment of social norms, to existing data collection systems.

7. By 2013, develop a method of collecting dating violence data not measured in existing surveillance systems.
8. By 2014, assess and report the extent to which youth violence (particularly, dating violence and bullying) occurs in Utah.

Objective 2: By the end of 2020, social norms that support healthy relationships will increase by 25% in Utah schools.

Activities
1. Through 2020, there will be designated person with responsibility for coordinating safety activities at school and promoting a school climate that demonstrates respect, support, and caring, and does not tolerate harassment or bullying.
2. Through 2020, continue to educate school personnel on the importance of establishing policies that address dating violence, in addition to disciplinary policies that are implemented consistently.
3. Through 2020, promote and increase the number of middle and high schools participating in Teen Dating Violence Awareness Month Activities (February) and Media Contest.
4. By 2017/18, assess the knowledge, attitudes, and behaviors of teenagers towards healthy relationships and dating violence.
5. Through 2020, continue to identify and promote dating violence prevention programs and curricula that are grounded in theory or that have scientific evidence of effectiveness.
6. Through 2020, continue to provide resources and funding to implement dating violence prevention curricula.
7. Through 2020, implement dating violence prevention curricula that are grounded in theory or have scientific evidence of effectiveness, and are consistent with national and state standards (CORE) for health education.
8. By the end of 2020, re-assess the knowledge, attitudes, and behaviors of teenagers towards healthy relationships and dating violence.
9. Through 2020, support and maintain the Utah Healthy Relationships Taskforce.

Objective 3: Through 2020, community-based organizations will expand partnerships and coalitions , in order to provide youth violence prevention resources and services

Activities
1. By 2012, ensure that school staff members are knowledgeable about dating violence and have the resources needed to prevent violence at school, at home, and in the community.
2. By 2013, train and support school personnel to be positive role models for a healthy and safe lifestyle.
3. By 2013, build partnerships with community resources, such as local domestic violence and rape crisis programs, and identify providers to bring services aimed at victims and perpetrators into the schools.

4. By 2014, coordinate school-based counseling, psychological, social, criminal justice and health services to meet the physical, mental, emotional, and social health needs of teenagers.
5. Through 2015, increase promotion of Utah's statewide domestic violence and rape crisis and information hotlines in schools.
6. Through 2015, provide resources to teenagers who have witnessed domestic or dating violence, who have been the victims of dating violence or harassment, and who are being victimized or harassed.

Objective 4: Through 2020, maintain statewide dating violence prevention coalition.

Activities
1. Through 2020, continue to diversify coalition membership by building partnerships with a variety of sectors (including, but not limited to partners in public health, academia, research, community-based organizations, law enforcement, education, etc.)
2. Through 2020, continue to update coalition goals, objectives, and strategies annually/biannually.
3. Through 2020, convene a minimum of two coalition meetings annually.
4. Through 2020, distribute a yearly satisfaction surveys with 100% of coalition members.
5. Through 2020, DVPAC and USVC will advise on prevention coalition goals, objectives, and strategies, as well as direction, twice annually.
6. Through 2020, continue to coordinate the statewide healthy relationships media contest for Utah youth.
7. Through 2020, promote and provide technical assistance to educators and schools interested in hosting teen dating violence awareness month activities.

Implementing Organizations
- Local junior high and high schools.
- Local police departments
    o Victim Advocates
- School counselors
- Sexual Assault Response Teams
- Utah Department of Health
    o Bureau of Maternal and Child Health
    o Sexually Transmitted Disease (STD) Control Program
    o Tobacco Prevention and Control Program
    o Violence and Injury Prevention Program
- Utah's Local Health Departments
- Utah PTA
- Utah School Boards Association
- Utah State Office of Education
- Utah School Superintendents Association

- Local domestic violence shelters
- Local rape crisis programs
- Utah Domestic Violence Coalition
- Utah Coalition Against Sexual Assault

Evidence-based Interventions/Best Practices
- Safe Dates Prevention Program for Dating Abuse http://www.hazelden.org/safedates
- Shifting Boundaries, building-level intervention
- Coaching Boys into Men: http://www.coachescorner.org/
- Bringing in the Bystander: http://cola.unh.edu/prevention-innovations-research-center/bringing-bystander%C2%AE-person-prevention-program
- Men Can Stop Rape http://www.mencanstoprape.org/
- Peace Over Violence http://peaceoverviolence.org/
- The Green Dot http://www.livethegreendot.com/

Poisoning

Overview

Drug poisoning deaths are a preventable public health problem and have outpaced deaths due to firearms, falls, and motor vehicle crashes in Utah. Every month, 49 Utahns die as a result of a drug poisoning, 82.3% of which are accidental or of undetermined intent, and of these, 74.8% involve opioids. Utah is particularly affected by prescription opioids, which are responsible for many of the drug poisoning deaths in Utah.

In 2013, the poison death rate for Utah was 23.25 per 100,000 population and is significantly higher than the U.S. rate of 15.2 per 100,000 population. In 2013, Utah ranked 5th in the U.S. for drug poisoning deaths[44].

Figure X
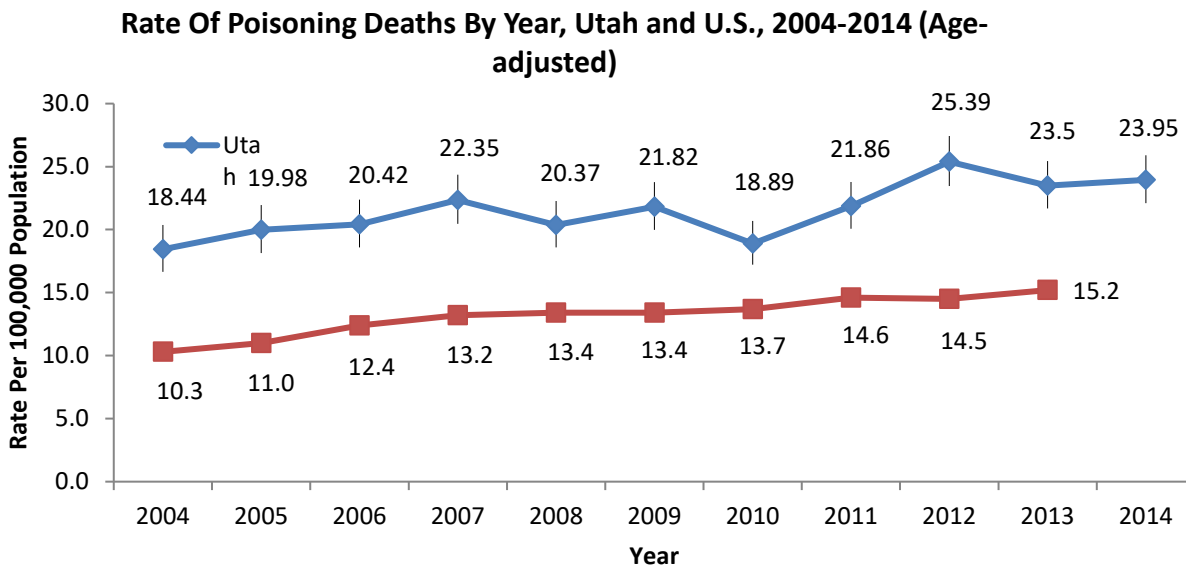
Rate Of Poisoning Deaths By Year, Utah and U.S., 2004-2014 (Age-adjusted)

Data, Surveillance and Costs

Age and Sex

Females have significantly higher poison ED visit and hospitalization rates compared to males. However, males have significantly higher poison death rates compared to females (2.5 and 1.7 per 10,000 population) (Figure X).

[44] [45] *IBIS Important Facts for Drug Overdose and Poisoning*
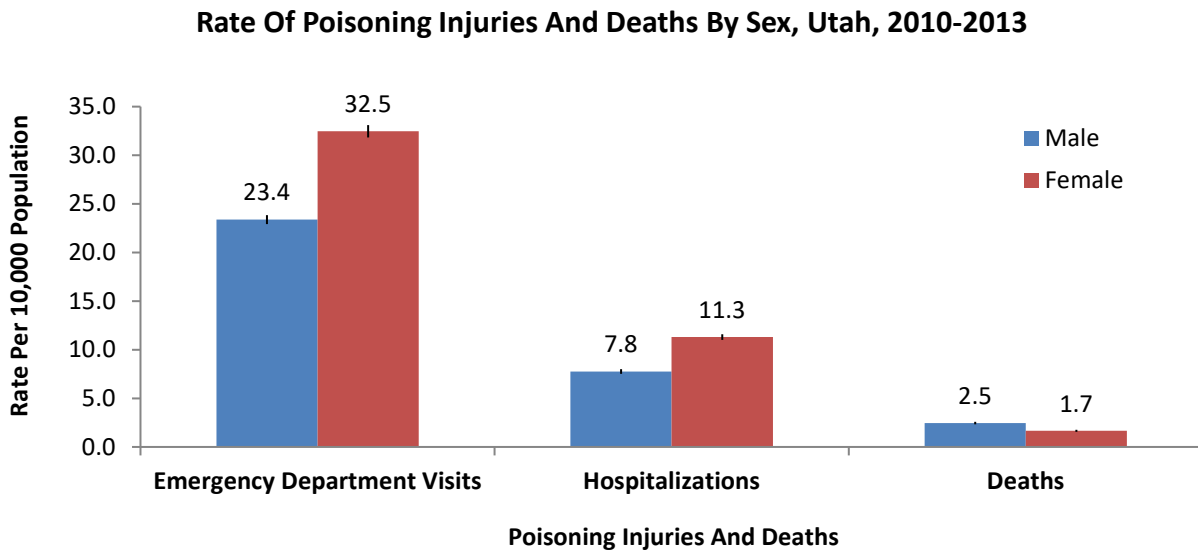
Figure X

Rate Of Poisoning Injuries And Deaths By Sex, Utah, 2010-2013

When broken down by age group, 15-17 year old males and females (32.8 and 65.4 per 10,000 population) had the highest poison ED visit rates among age groups. For poison hospitalizations, 18-24 year old males (9.2 per 10,000 population) and 35-44 year old females (14.8 per 10,000 population) had the highest rates among age groups.

Persons 45-54 had the highest poison death rate among males and females (42.2 and 35.5 per 100,000 population). Males 18-44 had significantly higher poison-related death rates compared to females (Figure X).

Figure X

Rate Of Poison-related Deaths By Age Group And Sex, Utah, 2010-2014

Prescription Opioid Deaths

Prescription pain medications underlie many Utah poisoning deaths. The majority of the increase in poison deaths occurred as a result of overdose of non-illicit drugs, which includes primarily prescription medications. In 2009, approximately 80% of the unintentional and undetermined poison deaths in Utah were due to prescription pain relievers, such as oxycodone, methadone, hydrocodone, and morphine.

In 2014, 15.6% of Utah poisoning deaths were of undetermined intent, 15.8% were self-inflicted, 68.4% were unintentional and less than 1% were homicides[45].

From 2012 to 2014, males (25.3 per 100,000 population) had a significantly higher age-adjusted drug poisoning death rate compared to females (18.7 per 100,000 population).

Healthy People 2020 Objectives

- IVP-9   Prevent an increase in the rate of poisoning deaths
- IVP-10   Prevent an increase in the rate of nonfatal poisonings
- MPS-2   (Developmental) Increase the safe and effective treatment of pain
- SA-12   Reduce drug-induced deaths
- SA-19   Reduce the past-year nonmedical use of prescription drugs

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By 20xx, at least one existing surveillance system will be improved to adequately monitor prescription drug abuse and overdose deaths in Utah youth aged 13-17.

Activities
1. Through 2020, identify primary users of information, assess their needs, and prioritize according to the results of the assessment.
2. Through 2020, continue use of the Utah Violent Death Reporting System (UTVDRS) for monitoring prescription drug overdose deaths in Utah.
3. Through 2020, continue to address data needs that are not covered by existing data sources.
4. By 2013, implement opportunities to add prescription and recreational drug overdose fatality components to existing data collection systems (e.g. UTVDRS) to gather more complete information about specialty populations at risk for prescription drug overdoses, including treatment data and criminal records in order to close gaps in prescription drug overdose death data collection.
5. Through 2020, maintain adequate level of epidemiological and support staff to collect, analyze, interpret, and evaluate prescription drug overdose fatality data.
6. Through 2020, review poisoning deaths of youth aged 13-17 at the Child Fatality Review Committee meetings.

Objective 2: Through the end of 2020, information from surveillance data will be disseminated to appropriate stakeholders.

Activities
1. Through 2020, identify and target surveillance data for specific audiences (e.g., policy makers, local health departments, school districts, etc.)
2. Through 2020, disseminate lessons learned from the Utah Prescription Drug Community Project (UPDCP)
3. Through 2020, evaluate data publications periodically as to their usefulness in helping local health districts and community-based organizations implement poisoning prevention strategies.
4. Through 2020, maintain adequate level of staff support to produce and disseminate prescription drug overdose data publications.
5. Through 2020, disseminate prescription drug abuse and overdose data via fact sheets as updates are available.

Objective 3: By the end of 2020, Utah's youth aged 13-17 and their parents/guardians will recognize that prescription drug abuse and overdose are preventable public health problems.

Activities
1. Through 2020, work with local substance abuse coalitions to address prescription drug abuse and overdoses in the 13-17 year old population.
2. Through 2020, implement evidence-based substance abuse prevention programs that target adolescents
    a. that are identified as being at risk of death or harm from prescription pain medication overdose.
3. Through 2020, annually administer the statewide survey to measure effectiveness and reach of the Use Only As Directed campaign, particularly for adolescents.
4. Through 2020, promote efforts to educate parents/guardians of 13-17 year old youth on proper use, storage, and disposal of prescription pain medications.
5. .

Objective 4: By the end of 2020, increase the number of trained providers on proper prescribing of opioids to youth including screening, treatment, and monitoring by 50%.

Activities
1. By 2012, meet with Division of Occupational and Professional Licensing (DOPL) to determine a baseline measure for this objective.
2. By 2012, pass legislation requiring CME for physicians prescribing opioids.
3. By 2012, define minimum course objectives for prescribing providers.
4. By 2013, ensure that options for CME on proper prescribing of opioids to youth are available to providers.
5. By 2014, review and revise Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain with any updated research findings.
6. Through 2020, collect additional data from DOPL to determine effectiveness of provider education.
7. Through 2015, provide support, grief counseling resources, and connections to community resources/opportunities to families who participate in the next of kin drug overdose death survey.
8. Through 2015, continue to disseminate the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain and continue to make CMEs available.
9. Through 2020, partner with the Division of Occupational and Professional Licensing to develop a tracking system of physicians who have been trained on the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain.

Objective 5: By the end of 2015, enhance participation in an existing agency with mental health and substance abuse as their mission.

Activities
1. By 2017, strengthen partnership with the Utah Department of Human Services, Division of Substance Abuse and Mental Health as evidenced by a Memorandum of Understanding.
2. By 2012, define and implement guidelines for substance abuse and mental health screening and referral to at-risk youth populations (e.g., juvenile incarcerated populations, etc.).
3. Through 2020, provide referrals for substance abuse and mental health services to youth aged 13-17.

Objective 6: By the end of 2020, increase utilization of options for proper disposal of prescription medications.

Activities
1. Through 2020, educate parents/guardians of youth aged 13-17 on proper disposal of unused and expired medication.
2. Through 2020, educate parents/guardians of youth aged 13-17 about locations for drop boxes and keep these locations updated at useonlyasdirected.org
3. Through 2020, support new legislation regarding options for disposal in other public locations.

Implementing Organizations
- American Academy of Family Physicians, Utah chapter
- Department of Environmental Quality
- Division of Occupational and Professional Licensing
- Drug Enforcement Agency
- Law Enforcement Agencies
- Local colleges and universities
- Utah Department of Health
  - Check Your Health
  - Prescription Pain Medication Management and Education Program
  - Violence and Injury Prevention Program
- Utah Department of Human Services
  - Division of Substance Abuse and Mental Health
- Utah's Local Health Departments
- Utah's Local Substance Abuse Authorities
- Utah Medical Association
- Utah National Alliance on Mental Illness
- Utah Nursing Association
- Utah Pharmacy Association
- Utah Pharmaceutical Drug Crime Project (UPDCP)
- Utah Poison Control Center

- Utah Psychiatrist Association
- Utah State Office of Education
- Utah PTA
- Local school districts

Evidence-based Interventions/Best Practices
- Celebrating Families http://www.celebratingfamilies.net
- [Partnership for Drug-Free America drugfree.org](http://drugfree.org)
- [NREPP list of evidence-based programming for substance abuse prevention](#)[Use only as directed](#)

Ages 18-24

Overview

Sexual assault affects thousands of Utahns each year. Studies in Utah indicate that one in eight women and one in 50 men will experience rape in their lifetimes[46] and nearly one in three women will experience some form of sexual violence during their lives.[47] Additionally, a national study showed one in four women and one in six men reported being a victim of child sexual abuse.[48]

Utah ranks 19th in the nation for reported forcible rapes.[49] Rape is the only violent crime in Utah that is higher than the national average. In a state where other violent crimes such as, homicide, robbery or aggravated assault, is historically half to three times lower than the national average, this is of concern. Since 2006, Utah's reported rape rate has been significantly higher than the U.S. reported rape rate. In 2014, Utah's reported rape rate was 67.7 per 100,000 females and the U.S. rate was 51.9 per 100,000 females (Figure X).[50]

Figure X

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[46] *Utah Department of Health. (2008).* Utah Health Status Update: Sexual Violence. *April 2008.*

[47] *Haddon, M., & Christenson, J (2005).* Rape in Utah. *Utah Commission on Criminal and Juvenile Justice.*

[48] *Dube, S.R., Anda, R.F., Whitfield, C.L., et al. (2005). Long-term consequences of childhood sexual abuse by gender of victim. American Journal of Preventive Medicine, 28, 430-438.*

[49] *U.S. Department of Justice. Federal Bureau of Investigation, (2008) Crime in the United States, 2007.* *http://www.fbi.gov/ucr/cius2007/ Accessed April 2009.*

[50] *Utah Department of Public Safety, (2008). Crime Statistics for the State of Utah.* *http://publicsafety.utah.gov/bci/crimestatistics.html Accessed February 2008.*

Rate Of Reported Rapes by Year, Utah And U.S. Females, 2006-2014
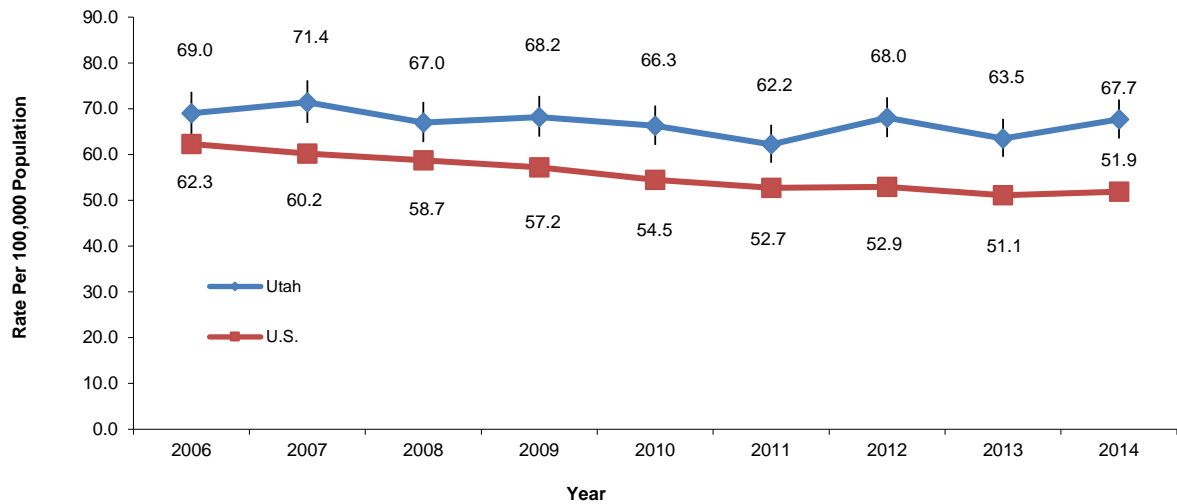
Data, Surveillance and Costs

Geographic Data

According to the Uniform Crime Reports, Uintah (101 per 100,000 population), Carbon (98 per 100,000 population), Salt Lake (95 per 100,000 population), Tooele (89 per 100,000 population), and Weber (80 per 100,000 population) counties had significantly higher reported rape rates than the state rate (72 per 100,000 population).

Age and Sex

Females have a significantly higher prevalence of rape or attempted rape than males (12.0% and 2.0%).[51] In the 2007 Rape in Utah Survey, 95.0% reported that the sexual assault was committed by a male.[52] Among male victims who experienced rape or attempted rape, there was no difference in perpetrator gender.[53] Males between the ages of 15-19 are arrested more frequently for rape than any other age group (Figure 13).[54]

In 2013, 8.9% of Utah female high school students have been physically forced to have sexual intercourse when they did not want to, compared to 5.9% of male high school students.

Healthy People 2020 Objectives
- **IVP-32**   Reduce sexual violence

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[51] *2006 Utah Behavioral Risk Factor Surveillance System. Office of Public Health Assessment.*

[52] *Mitchell, C., & Peterson, B., (2007).* Rape in Utah, 2007. *Utah Commission on Criminal and Juvenile Justice.*

[53] *Haddon, M., & Christenson, J (2005).* Rape in Utah. *Utah Commission on Criminal and Juvenile Justice.*

[54] *Haddon, M., & Christenson, J (2005).* Rape in Utah. *Utah Commission on Criminal and Juvenile Justice.*

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

> **Objective 1:** To advance social norms among Utah youth ages 11-25 that support healthy, respectful relationships throughout the lifespan.

Activities
1. By 2017, collect baseline data on social norms surrounding relationships, violence, and gender roles as they exist in Utah.
2. Ongoing, require all RPE-funded programs to target youth ages 11-25 with evidence-based curriculums and strategies for preventing sexual violence.
3. By 2017, identify? (have these been developed?) state, regional, and community coalitions to:
    a. Recruit community leaders to champion and advance the values of respect and healthy relationships
    b. Reach the majority of the population with messages on respect, gender equality, and healthy relationships within their communities through:
        i. Media messaging
        ii. Training bystanders
        iii. Modeling
        iv. Educational seminars
        v. In-service training
        vi. Establish primary prevention initiatives in their communities.
4. In 20XX, create a Sexual Violence Prevention Alliance represented by all state, regional, and community coalitions in Utah.
5. By 20XX, partner with public and private schools to implement evidence-based programs in their schools to increase protective factors and reduce risk factors for sexual violence victimization and perpetration.
6. Provide ongoing technical assistance and training on engaging men and boys in prevention efforts. To: RPE grantees, etc.

> **Objective 2:** To increase primary prevention efforts and social norm change to geographically disparate communities and populations.

Activities

1. By 2017, identify key leaders and groups within the counties and work with their communities to establish coalitions to address sexual violence prevention or to join existing coalitions focused on problems with overlapping risk and protective factors
2. By 2017, conduct community needs assessments in each of the counties to determine the needs and conditions that must be addressed in order to prevent sexual violence.
3. Provide ongoing training and technical assistance to support the prevention coalitions in developing prevention initiatives.

Objective 3: To build the capacity of individuals, organizations, communities, and systems to prevent
sexual violence across the state.

Activities
1. By 2017, conduct community needs assessments in each of the counties to determine the needs and conditions that must be addressed in order to prevent sexual violence.
2. By 2017, conduct surveillance on sexual violence (SV) and its relationship to adverse childhood experiences (ACE) through the SV and ACE modules of the BRFSS. Publish the findings.
3. Continue to encourage and support research into identifying the prevalence and dynamics of sexual violence in Utah.
   Improve data collection regarding sexual violence perpetration and victimization.

Objective 4: By the end of 2020, increase state and community readiness for adoption of of the Rape Prevention Education Model of Community Change in Utah.

Activities
1. Through 2020, in collaboration with the Utah Coalition Against Sexual Assault (UCASA), disseminate information to Rape Prevention Education grantees and other state and local agencies on the Rape Prevention Education Model of Community Change.
2. Through 2020, coordinate with UCASA to identify new and existing partners to support and actively participate in the implementation of the statewide strategic plan for sexual violence prevention.
3. Through 2020, UCASA staff will provide ongoing training and technical assistance to identified partners in state and local agencies on conducting community readiness assessments and implementing evidence-based primary prevention strategies within their communities.

Objective 5: By the end of 2020, prevention coalitions, addressing sexual violence, will be functioning in all Utah counties.

Activities
1. By 2018, identify at least 200 partners in counties, cities, judicial districts, health districts, tribal, or other organizations and invite them to attend a statewide sexual

violence prevention partnership forum for the purpose of advancing coalition and capacity building as well as primary prevention.

2. By 2017, work with coalitions to research and share evidence-based prevention strategies for use in their communities.

3. Through 2020, provide technical assistance and training to the coalitions on fund raising to support community primary prevention efforts.

Implementing Organizations
- Local colleges and universities
- Utah Department of Health
    - Violence and Injury Prevention Program
- Utah's Local Health Departments
- Utah Coalition Against Sexual Assault
- Utah Domestic Violence Coalition
- Utah Commission on Criminal and Juvenile Justice
- Utah Sexual Violence Council

**Evidence-based Interventions/Best Practices**

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Family Violence

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Overview

Family violence includes domestic violence (psychological/emotional, physical, and sexual abuse or threats of these), intimate partner violence, and sexual assault (rape or attempted rape, child sexual abuse, and dating/domestic sexual abuse). Child abuse and teen dating violence are addressed in the Birth-14 years and 15-17 years sections of the plan.

There is approximately one domestic violence-related homicide each month in Utah (5). In 2012, more than 3,114 men, women, and children entered shelters to escape domestic violence[55]. In 2011, 53% of homicides were domestic violence related. (Figure X)

Figure X

Percentage Of Homicides By Homicide Type, Utah Adults, 2000-2011

Percent

Domestic violence-Related   Non-domestic Violence-related
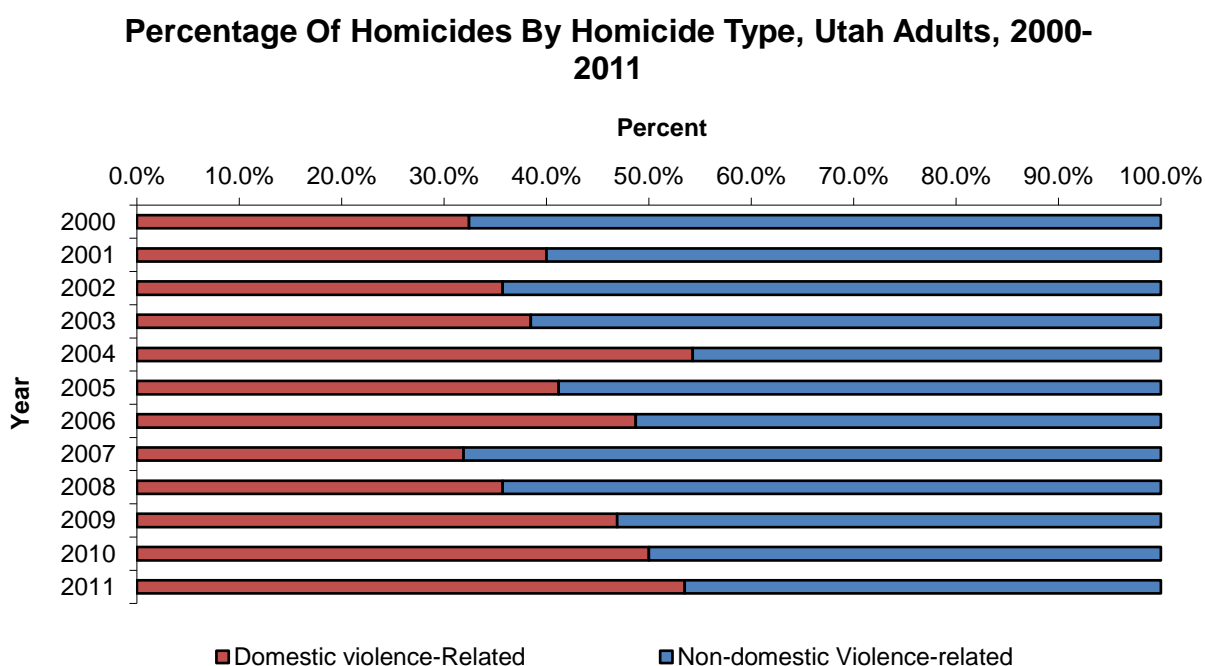
Data, Surveillance and Costs

Sex and Age

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[55] *No more secrets. Utah's domestic and sexual violence reports, 2013.*

Males have a significantly higher domestic violence-related homicide perpetrator rate than females (1.6 and .3 per 100,000 adults, respectively).[56] There was not a significant difference among domestic violence-related homicide victims by gender and age group.[56]

Males also have a significantly higher domestic violence-related suicide rate than females (4.5 and 0.6 per 100,000 adults).[57] There were no significant differences among age groups in domestic violence-related suicide victims, homicide victims, or homicide perpetrators.[58]

Healthy People 2020 Objectives
- **IVP-31**   Reduce violence by current or former intimate partners
- **IVP-42**   Reduce children's exposure to violence

Prevention Strategies
The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

> **Objective 1: By the end of 2020, social norms supportive of hostility toward women and girls, family violence, male superiority and sexual entitlement will decrease by half.**

Activities
1. By 2017, collect baseline data on social norms surrounding relationships, violence, and gender roles as they exist in Utah.
2. Through 2020, partner with public and private schools and community agencies to promote and provide information on evidence-based primary prevention initiatives/programs to increase protective factors and reduce risk factors of family violence victimization and perpetration.
3. Through 2020, recruit community leaders to champion and advance the value of respect and healthy relationships.
4. Through 2020, educate at least 2,000 Utahns about respect, gender equality, and healthy relationships within their communities through media messaging, bystander intervention training, modeling, educational seminars, in-service training, etc.
5. By 2020 re-assess social norms surrounding relationships, violence, and gender roles as they exist in Utah.

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[56] *2000-2002 Domestic Violence Fatalities in Utah Report*
[56] *2000-2002 Domestic Violence Fatalities in Utah Report*
[57] *2000-2002 Domestic Violence Fatalities in Utah Report*
[58] *2000-2002 Domestic Violence Fatalities in Utah Report, 2005-2006 UTVDRS*

Objective 2: By the end of 2020, build the understanding of family violence through collection of data on protective factors and risk factors.

Activities
1. By 2017, conduct community needs assessments in each of Utah's counties to determine the needs and conditions that must be addressed in order to prevent family violence.
2. By 2017, conduct surveillance on intimate partner violence (SV) and its relationship to adverse childhood experiences (ACE) through the IPV and ACE modules of the BRFSS.
3. By 2018, disseminate the findings of the IPV and ACE modules.
4. Through 2020, continue to encourage and support research into identifying the prevalence and dynamics of family violence in Utah.
5. Through 2020, improve data collection around family violence perpetration and victimization.

Objective 3: By the end of 2020, obtain dedicated family violence prevention funding, in addition to federal money already allocated to Utah, for state prevention efforts and community grassroots efforts.

Activities
1. By 2019, publish a document detailing the costs of family violence on the state of Utah to use as bargaining source for prevention funding.
2. Through 2020, research opportunities for funding through state, local foundations, and other philanthropic organizations.
3. Through 2020, provide technical assistance to communities or apply directly for funding for family violence prevention initiatives or strategies.

Implementing Organizations
- Local colleges and universities
- Utah Department of Health
    - Violence and Injury Prevention Program
- Utah's Local Health Departments
- Utah Coalition Against Sexual Assault
- Utah Domestic Violence Coalition
- Utah Commission on Criminal and Juvenile Justice
- Utah Sexual Violence Council

Motor Vehicle Crashes

Overview

Motor vehicle crashes[59] (MVC) are the second leading cause of injury death, behind poisoning, for all ages in Utah. Motor vehicle crashes may include occupants in motor vehicles (driver and passengers), motorcyclists, bicyclists, pedestrians, and All Terrain Vehicle/Off Highway Vehicles (ATV/OHV).

Utah's rate of MVC traffic[60] occupants[61] deaths decreased since 2006 (Figure X).
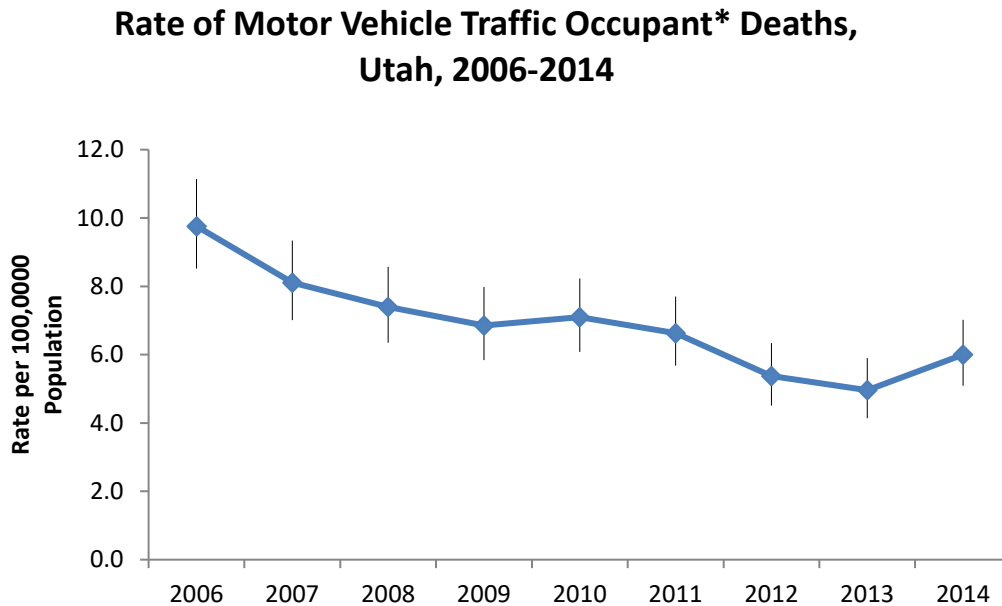
Figure X

Rate of Motor Vehicle Traffic Occupant* Deaths, Utah, 2006-2014

*Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators

However, motorcyclist[62] , bicyclist[63] , pedestrian[64] , and ATV/OHV[65] deaths have remained fairly consistent during this time (Figure X).

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[59] *Motor Vehicle Crashes include eight indicators on IBIS: 1) MV traffic-occupant injured, 2) MV traffic-motorcyclist injured, 3) MV traffic-pedal cyclist injured, 4) MV traffic-pedestrian injured, 5) MV traffic-other and unspecified, 6) pedal cyclist MV non-traffic and other, 7) pedestrian MV non-traffic and other, and 8) other MV non-traffic and other.*
[60] *MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified.*
[61] *Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators.*
[62] *Motorcyclists include those in the MV traffic-motorcyclist injured indicator.*
[63] *Bicyclists include those in the MV traffic-pedal cyclist injured and pedal cyclist MV non-traffic and other indicators.*

Figure X

Rate Of Other Motor Vehicle Deaths by Type, Utah, 2006-2014

*Due to the small numbers, results should be interpreted with caution.

Since 2006, Utah has had a lower MVC traffic death rate than the U.S. (Figure X).[65]

Figure X

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[64] *Pedestrians include those in the MV traffic-pedestrian injured and pedestrian MV non-traffic and other indicators.*
[65] *ATV/OHV deaths include those in other MV non-traffic and other indicator.*
[66] *WISQARS*

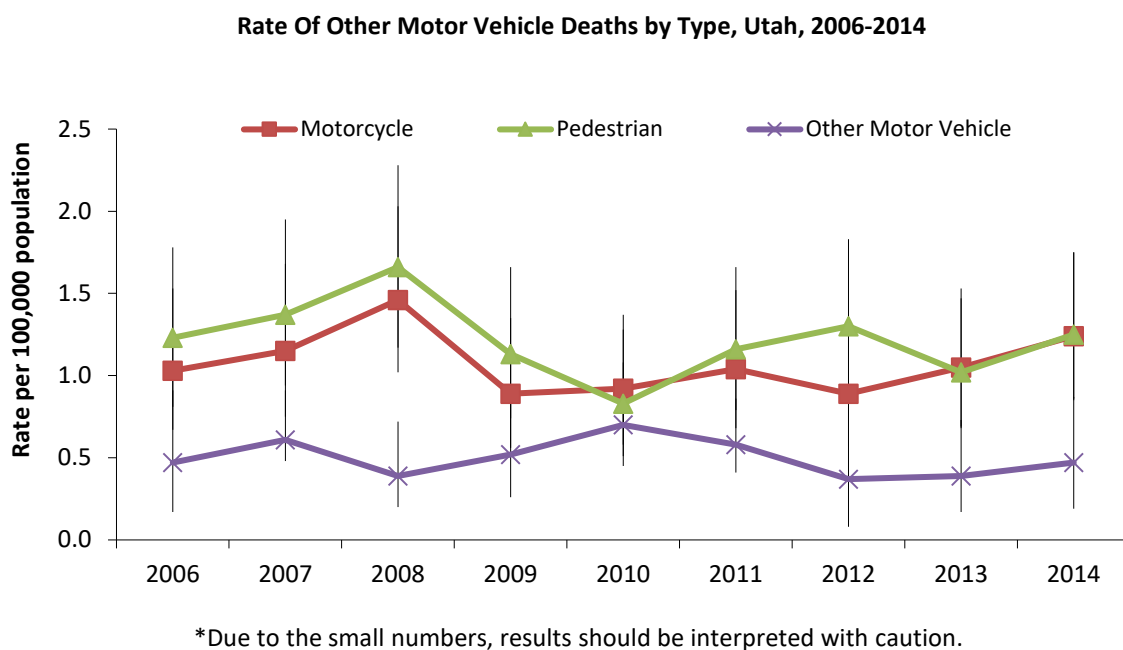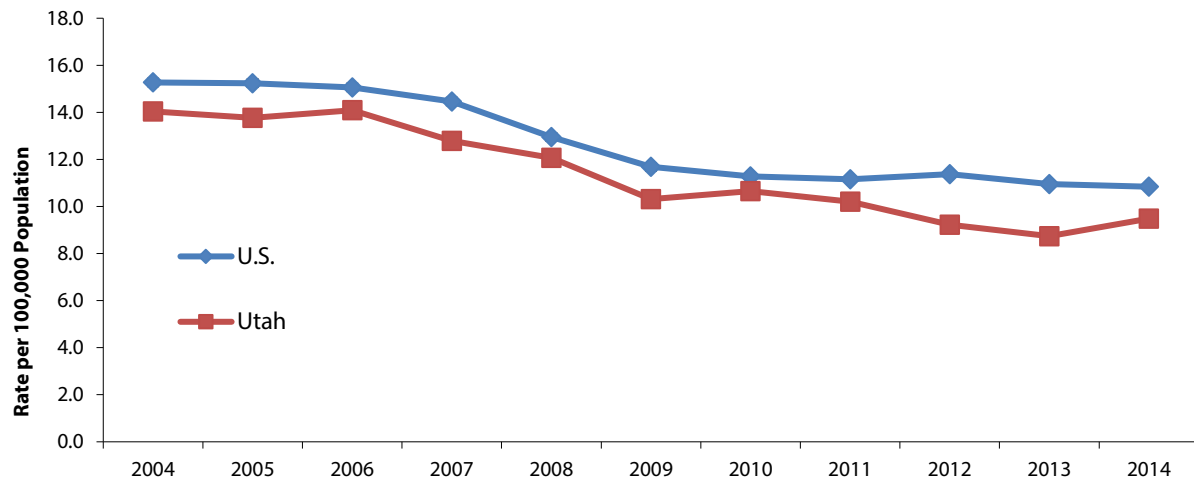**Rate of Motor Vehicle Traffic* Deaths, Utah and U.S., 2004-2014**

*MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified

In 2014, Utah's MVC traffic death rate for all ages was 8.16 per 100,000 population compared to the U.S. age-adjusted MVC death rate of 10.58 per 100,000 population[66].

Data, Surveillance and Costs

Geographic
In 2014, Weber-Morgan HD had the highest MVC traffic ED visit rate for all ages at 73 per 10,000 population among local health districts. Tooele HD had the highest MVC traffic hospitalization rate for all ages at 6.01 per 10,000 population while Tricounty HD had the highest MVC traffic death rate for all ages at 25.7 per 100,000 population among local health districts.

Other HDs and small areas with significantly higher and lower MVC rates than the state rate can be found in Appendix X.

Race and Ethnicity[67]
From 2010-2014, American Indians/Alaskan Natives (32.0 per 100,000 population) had a higher rate of MVC traffic deaths than White persons (7.6 per 100,000 population) and Black persons (6.3 per 100,000 population) (Figure X). However, statistical significance could not be calculated because case-level data was not available.

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[67] IBIS

Figure X

Rate of Motor Vehicle CrashTraffic Deaths by Race, Utah, 2010-2014 (Age-Adjusted)

Healthy People 2020 Objectives
- IVP-13   Reduce motor vehicle crash-related deaths
- IVP-14   Reduce nonfatal motor vehicle crash-related injuries
- IVP-15   Increase use of safety belts
- IVP-16   Increase age-appropriate vehicle restraint system use in children
- IVP-17   Increase the number of States and the District of Columbia with "good" graduated driver licensing (GDL) laws
- IVP-18   Reduce pedestrian deaths on public roads
- IVP-19   Reduce nonfatal pedestrian injuries on public roads
- IVP-20   Reduce pedal cyclist deaths on public roads
- IVP-21   Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders
- IVP-22   Increase the proportion of motorcycle operators and passengers using helmets

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: Expand the "Don't Drive Stupid" campaign to address young adults ages 18-24.

Activities

1. By 2018, determine effectiveness of the "Don't Drive Stupid" messaging in changing driving behaviors for young adults ages 18-24
2. By 2017, expand the "Don't Drive Stupid" educational/grassroots efforts to college, university, and trade school program settings.
3. Through 2020, personalize messages to communities based on local stories and local data.
4. Through 2020, educate young drivers through employment settings on the dangers of cell phone use and texting while driving.
5. Through 2020, maintain consistent messaging with the Zero Fatalities campaign but recycle messages to keep them fresh.

Objective 2: Continue implementation of the "Alive at 25" Program.

Activities

1. Through 2020, maintain current level of staff support to continue implementation of the "Alive at 25" Program.
2. By 2018, increase implementation of the "Alive at 25" Program by 25%.
3. By the end of 2020, evaluate success of the "Alive at 25" Program and disseminate results to stakeholders.

Objective 3: Enact policies/legislation regarding motor vehicle safety.

Activities

1. Through 2020, continue to enforce handheld cell-phone-use-while-driving ban law.
2. Through 2020, increase education to elected officials and policy makers on motor vehicle-related trends and challenges through a minimum of two fact sheets, briefings, or other educational activities.
3. Through 2020, provide at least two data-driven fact sheets on MVC-related legislation to advocates, Utah Legislature, and other stakeholders.
4. By 2020, pass legislation banning hands-free use of cell phones while driving for all ages.
5. Through 2020, evaluate and support policies/legislation regarding distracted driving, impaired driving, drowsy driving, and aggressive driving.
6. By end of 2020, explore legislation to strengthen and improve Utah's graduated driver's license requirements.
7. By end of 2020, pass legislation requiring a mandatory educational class for teens who receive a ticket because they were not wearing a seat belt.
8. By 2020, explore legislation that would require teens to retake driver education again if they receive a certain number of tickets within a given time frame.

9. By 2018, complete an evaluation of the Primary Seatbelt Law.
10. By 2019, work with stakeholders to help make the Primary Seatbelt Law permanent.
11. Yearly, through 2020, promote workplace policies prohibiting employees from using cell phones while driving on company business.

Objective 4: Continue surveillance of MVC injuries and deaths.

Activities

1. Through 2020, ensure capacity for the production and dissemination of motor vehicle crash-related publications.
2. Through 2020, collaborate with the Utah Highway Safety Office to identify and target surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
3. Through 2020, leverage existing surveillance systems and data sources to collect motor vehicle crash-related data.
   a. Driving behaviors through BRFSS, SHARP (YRBSS/PNA)
   b. Impaired driving, specifically opioid intoxication in fatal crashes (UTVDRS)
   c. General crash fatality data FARS/NVDRS

4. Through 2020, collaborate with the Utah Highway Safety Office to identify and target surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
5. Through 2020, maintain publicly accessible data query system through the Indicator Based Information System for Public Health (IBIS-PH).
6. Through 2020, develop and update fact sheets and data reports on an annual basis.

Implementing Organizations
- American Automobile Association (AAA), Utah chapter
- Insurance companies
- Law enforcement agencies
- Utah's 12 Local Health Departments
- Utah colleges, universities, and trade school programs
- Utah Department of Health
  - Violence and Injury Prevention Program
- Utah Department of Public Safety
  - Utah Highway Safety Office
- Utah Department of Transportation
- Utah Safety Council
- Zero Fatalities campaign

Evidence-based Interventions/Best Practices

- National Safety Council, Alive at 25 curriculum http://aliveat25.us/
- Zero Fatalities http://ut.zerofatalities.com/

Poisoning

**Overview**

Drug poisoning deaths are a preventable public health problem and have outpaced deaths due to firearms, falls, and motor vehicle crashes in Utah. Every month, 49 Utahns die as a result of a drug poisoning, 82.3% of which are accidental or of undetermined intent, and of these, 74.8% involve opioids. Utah is particularly affected by prescription opioids, which are responsible for many of the drug poisoning deaths in Utah.

In 2013, the poison death rate for Utah was 23.25 per 100,000 population and is significantly higher than the U.S. rate of 15.2 per 100,000 population. In 2013, Utah ranked 5th in the U.S. for drug poisoning deaths[68].

Figure X
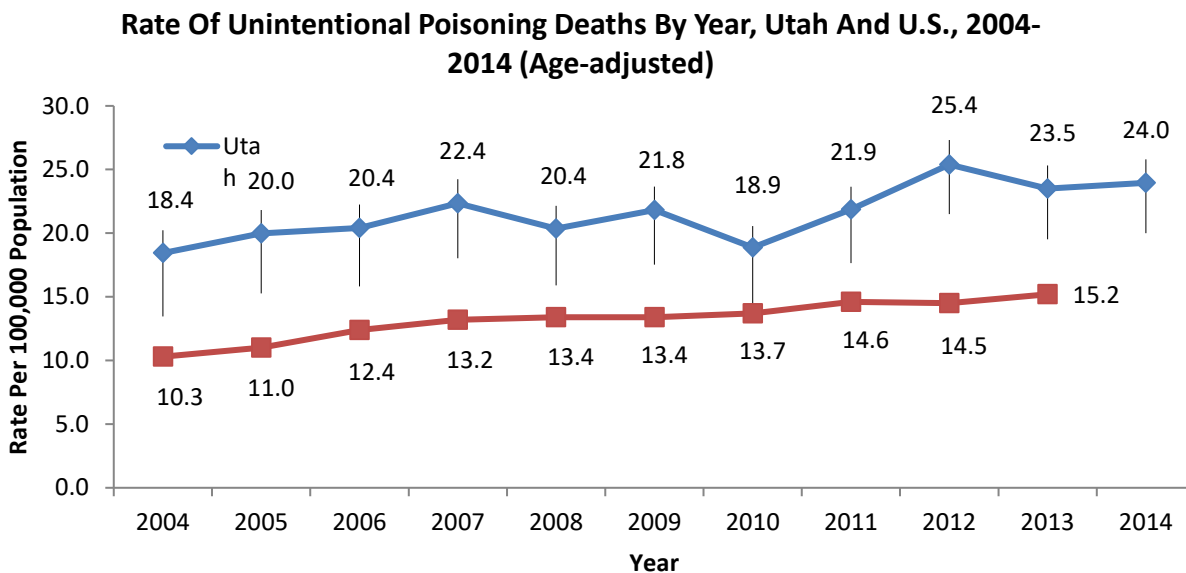
Rate Of Unintentional Poisoning Deaths By Year, Utah And U.S., 2004-2014 (Age-adjusted)

Data, Surveillance and Costs

Age and Sex

Females have significantly higher poison ED visit and hospitalization rates compared to males. However, males have significantly higher poison death rates compared to females (22.5 and 15.7 per 100,000 population) (Figure X).

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[68][69] *IBIS Important Facts for Drug Overdose and Poisoning*

Figure X

Rate Of Poisoning Injuries And Deaths By Sex, Utah, 2010-2013

When broken down by age group, 15-17 year old males and females (32.8 and 65.4 per 10,000 population) had the highest poison ED visit rates among age groups. For poison hospitalizations, 18-24 year old males (9.2 per 10,000 population) and 35-44 year old females (14.8 per 10,000 population) had the highest rates among age groups.

Persons 45-54 had the highest poison death rate among males and females (48.5 and 46.5 per 100,000 population). Males 18-44 had significantly higher poison-related death rates compared to females (Figure X).

Figure X

Rate Of Poison-related Deaths By Age Group And Sex, Utah, 2010-2014

Prescription Opioid Deaths

Prescription pain medications underlie many Utah poisoning deaths. The majority of the increase in poison deaths occurred as a result of overdose of non-illicit drugs, which includes primarily prescription medications. In 2009, approximately 80% of the unintentional and undetermined poison deaths in Utah were due to prescription pain relievers, such as oxycodone, methadone, hydrocodone, and morphine.

In 2014, 15.6% of Utah poisoning deaths were of undetermined intent, 15.8% were self-inflicted, 68.4% were unintentional and less than 1% were homicides[69].

From 2012 to 2014, males (25.3 per 100,000 population) had a significantly higher age-adjusted drug poisoning death rate compared to females (18.7 per 100,000 population).

Healthy People 2020 Objectives

- IVP-9   Prevent an increase in the rate of poisoning deaths
- IVP-10   Prevent an increase in the rate of nonfatal poisonings
- MPS-2   (Developmental) Increase the safe and effective treatment of pain
- SA-12   Reduce drug-induced deaths
- SA-19   Reduce the past-year nonmedical use of prescription drugs

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By the end of 2020, at least one existing surveillance system will be improved to adequately monitor prescription drug overdose deaths in Utah.

Activities

1. By 2020, identify primary users of information, assess their needs, and prioritize according to the results of the assessment.
2. By 2016, explore the Utah Violent Death Reporting System (UTVDRS) for its usefulness in monitoring prescription drug overdose deaths in Utah.
3. By 2017, develop a list of data needs that are not covered by existing data sources.
4. By 2017, implement opportunities to add prescription drug overdose fatality components to existing data collection systems (e.g. UTVDRS) to gather more complete information about specialty populations at risk for prescription drug overdoses, including treatment data and criminal records in order to close gaps in prescription drug overdose death data collection.
5. By 2017 create a template to improve narratives from medical examiner investigators identifying specific drugs on scene.
6. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate prescription drug overdose fatality data.
7. Through 2020 improve Rapid Response initiatives.

Objective 2: By the end of 2020, information from surveillance data will be disseminated to appropriate stakeholders.

Activities

1. By 2016, identify and target surveillance data for specific audiences (e.g., policy makers, local health departments, etc.).
2. By 2016, disseminate lessons learned from the Utah Prescription Pain Medication Management and Education Program.
3. By 2017, evaluate data publications as to their usefulness in helping local health districts and community-based organizations implement poisoning prevention strategies.
4. By 2018 data collection will increase to include morbidity, use, misuse, and abuse.
5. Through 2020, maintain current level of staff support to produce and disseminate prescription drug overdose data publications.
6. Through 2020 disseminate at least two prescription drug overdose fact sheets.
7. Through 2020 work with DOPL to increase monitoring of high-risk prescribers and dispensers of opioid medication.

Objective 3: By the end of 2020, more than half of Utah's general population will recognize that prescription drug overdose is a preventable public health problem.

Activities

1. By 2012, identify baseline measure using responses to the Use Only as Directed statewide survey.
2. By 2017, convene at least one conference to address prescription drug o v e r d o s e s .
3. By 2016, compile a summary report on progress made regarding the Prescription Pain Medication Program activities.
4. By 2014, implement evidence-based substance abuse prevention programs that target persons that are identified as being at risk of death or harm from prescription pain medication overdose.
5. By 2017, administer the statewide survey to measure effectiveness and reach of the Use Only as Directed c a m p a i g n .
6. Through 2020, increase public knowledge on signs and symptoms of an overdose and risk factors for abuse and addiction.
7. Through 2020, promote efforts to educate the public on proper use, storage, and disposal of prescription pain medications via media outlets.
8. Through 2020, continue statewide collaboration to implement the activities and recommendations of the Utah Pharmaceutical Drug Crime Project.
9. Through 2020, promote prescription drug overdose public awareness events sponsored by organizations such as Utah Pharmaceutical Drug Crime Project, Division of Substance Abuse and Mental Health, Department of Environmental Quality, and Drug Enforcement Agency.
10. Through 2020, increase education and awareness of the Good Samaritan law through a media campaign.

Objective 4: By the end of 2020, increase the number of trained providers on proper prescribing of opioids including screening, treatment, and monitoring by 50%.

Activities

1. By 2017, meet with Division of Occupational and Professional Licensing (DOPL) to determine a baseline measure for this objective.
2. By 2016, pass legislation requiring continuing medical education (CME) credits for CME on proper prescribing of opioids are available to providers.
3. By 2016, review and revise Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain with any updated research findings. Explore ways to incorporate guidelines into electronic medical records.
4. By 2017, collect additional data from DOPL to determine effectiveness of provider education.
5. By the end of 2018 incorporate prescription drug abuse prevention materials in school based prevention curriculum.
6. By 2017, include dashboard development; work with health systems to disseminate data.

Objective 5: By the end of 2020, enhance participation in an existing agency with mental health and substance abuse as their mission.

Activities

1. By 2012, strengthen partnership with the Utah Department of Human Services Division of Substance Abuse and Mental Health as evidenced by a Memorandum of Understanding.
2. By 2018, define and implement guidelines for substance abuse and mental health screening and referral to at-risk populations (e.g., uninsured and non-Medicaid, students in universities and colleges, adult and juvenile incarcerated populations, e t c .).
3. Through 2020, promote risk assessments with providers.
4. Through 2020, provide referrals for substance abuse and mental health services to the community.
5. By 2018, increase education and number of providers using medication assisted treatment.

Objective 6: By the end of 2020, increase availability and knowledge of options for proper disposal of prescription medications disposal options.

Activities

1. Through 2020, educate the public on proper disposal of unused and expired medication.
2. Through 2020, educate public about locations for drop boxes and keep these locations updated at www.useonlyasdirected.org.
3. By 2017, will have evaluated UOAD media campaign and drop boxes.
4. Through 2020, provide information to public about disposal options and current best practices-by 2016; provide public with a referral directory.
5. By 2017, evaluate the Use Only as Directed campaign, including pharmacy drop boxes.

Objective 7: Through 2020, increase the education about the opioid drug antagonist Naloxone, and increase knowledge of HB 119 to providers, pharmacies, and the public.

Activities

1. Through 2020 collect Naloxone distribution and administration data.
2. Through 2020 increase the availability of naloxone.
3. By 2017, create a phone application increasing availability of information on recognizing an overdose and naloxone administration and use.

4. Through 2020 make naloxone widely available to individuals with opiate misuse/abuse/addiction and who are at risk of overdose.

Implementing Organizations

- American Academy of Family Physicians, Utah chapter
- Department of Environmental Quality
- Division of Occupational and Professional Licensing
- Drug Enforcement Agency
- Law Enforcement Agencies
- Department of Education-Prevention Dimensions
- Local colleges and universities
- Utah Department of Health
  - o Check Your Health
  - o Prescription Pain Medication Management and Education Program of Violence and Injury Prevention Program
- Utah Department of Human Services
  - o Division of Substance Abuse and Mental Health
- Utah's 12 Local Health Departments
- Utah's Local Substance Abuse Authorities
- Utah Medical Association
- Utah National Alliance on Mental Illness
- Utah Nursing Association
- Utah Pharmacy Association
- Utah Pharmaceutical Drug Crime Project (UPDCP)
- Utah Poison Control Center
- Utah Psychiatrist Association

Evidence-based Interventions/Best Practices

- Celebrating Families http://www.celebratingfamilies.net
- Colorado Consortium corxconsortium.org
- Improving pain treatment through education painedu.org
- SAMSHA dpt.samsha.gov/providers/prescribing courses
- The partnership at Drug Free.org drugree.org
- CADCA National Youth Leadership Initiative cadca.org/about-nyli

Suicide Attempts and Fatalities

Overview

From 2012-2014, Utah's age adjusted suicide rate was 20.8 per 100,000 persons. All suicide attempts should be taken seriously. Those who survive suicide attempts are often seriously injured and need medical care. Many have depression and other mental health problems. Most people feel uncomfortable talking about suicide. Victims are frequently blamed and families stigmatized. Friends, families, and communities may feel shock, anger, guilt, and depression and are usually left devastated.[70]

In 2014, suicide was the leading cause of death for Utahns ages 10 to 17 and the overall eight leading cause of death for Utahns ages 10+. Completed suicides are only part of the problem. More people are hospitalized or treated in an emergency room for suicide attempts than are fatally injured. In 2013, 13 Utahns were treated for self-inflicted injuries every day (3,181 emergency department visits and 1,508 hospitalizations).

Data, Surveillance and Costs

Age and Sex

When broken down by age group, 18-24 year old males had the highest rate of hospitalizations for suicide attempts at 7.5 per 10,000 population. For females, the highest hospitalization rate for suicide attempts was seen in 15-17 year olds at 11.2 per 10,000 population (Figure X).

The highest ED visits for suicide attempts was seen in 15-17 year old males (21.9 per 10,000 population) and females (52.6 per 10,000 population).

Persons 35-44 and 45-54 had the highest suicide death rates both at 22.4 per 100,000 population (Figure X).

Figure X

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[70]*Centers for Disease Control and Prevention.* Understanding Suicide Fact Sheet 2006. *National Center for Injury Prevention and Control.*
IBIS Health Indicator Report, Suicide.

Rate Of Self Inflicted Injury Emergency Department Visits By Age Group and Sex, Utah, 2010-2013
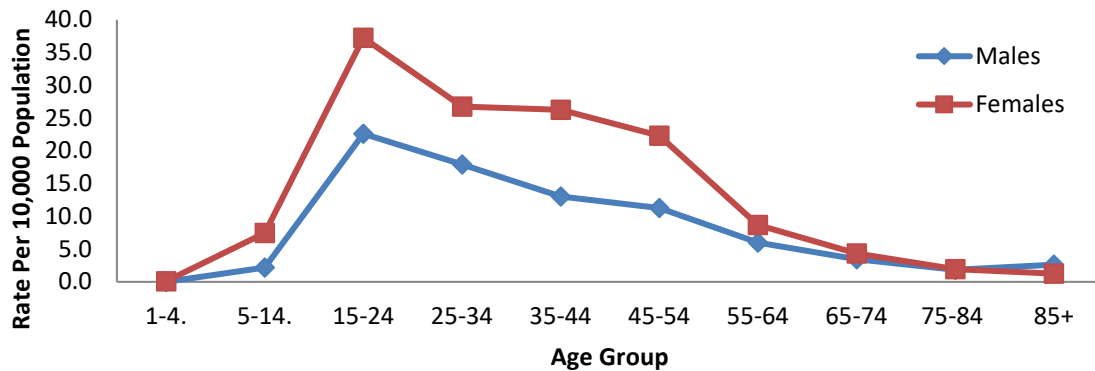
According to the Youth Risk Behavior Survey, females are more likely to report feeling sad or hopeless compared to males (32.4 percent and 21.7 percent). In addition, females are more likely to make a suicide plan compared to males (14.9 percent and 10.7 percent) (Figure X).

Rate of Self Inflicted Injury Hospitalizations By Age Group and Gender, Utah, 2010-2013
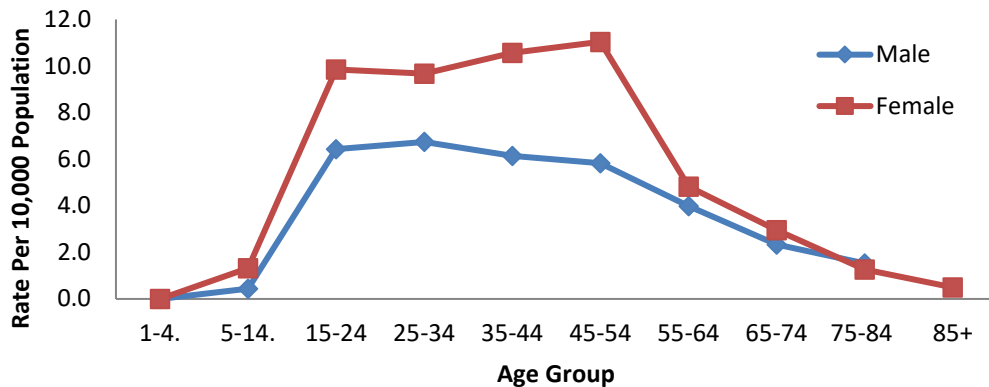
Method of Suicide Attempts and Suicides Deaths

The most common method of injury for suicide attempts for Utahns ages 18-24 was poisoning followed by cut/pierce for both males and females. The most common method of injury for suicide deaths for Utahns ages 18-24 was firearm for males and suffocation for females.

Healthy People 2020 Objectives
- **IVP-41**   Reduce nonfatal intentional self-harm injuries
- **ECBP-2**   Increase the proportion of college and university students who receive information from their institution on each of the priority health risk behavior areas (all priority areas; unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; and inadequate physical activity)
- **MHMD-1**   Reduce the suicide rate

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By the end of 2020, evaluate existing surveillance systems to adequately monitor and measure risk and protective factors for suicide, suicide deaths, and suicide attempts in Utah.

Activities
1. By 2020, continue to work with existing partners and identify additional users of information, assess their needs, and prioritize according to the results of the assessment.
2. By 2020, evaluate the Utah Violent Death Reporting System and the Behavioral Risk Factor Surveillance System for their usefulness in monitoring utilization of mental health and substance use services, risk and protective factors for suicide, suicide ideation, suicide deaths, and attempted suicides in Utah.
3. By 2018, develop a list of data needs that are not covered by existing data sources.
4. By 2020, add suicide components to existing data collection systems to gather more complete information about populations at risk for suicide, to screen for distress and dysfunction associated with mental illness, and to close gaps in suicide data collection.
5. By 2020, collaborate with partners such as Law Enforcement and the LGBT Committee of the Utah Suicide Prevention Coalition to determine and implement methods to collect, analyze, and interpret more comprehensive data relating to LGBT risk factors, suicide attempts, and death rates in Utah.
6. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate suicide data.
7. By 2020, organize and implement a Suicide Fatality Review Committee involving key partners, and regularly share recommendations from the committee with agencies in Utah.

8. By 2020, evaluate Parent Seminars on Youth Protection for feasibility, attendance, and effectiveness, and make recommendations for improvement if necessary.
9. By 2020, develop a Utah suicide prevention research agenda with comprehensive input from multiple stakeholders; then carry out at least one suicide prevention research/evaluation project and disseminate the results.
10. By 2020, identify ways to increase the tracking and coordination of statewide efforts in suicide prevention. By 2020, compile a summary report on progress made regarding the Utah Suicide Prevention Plan.

Objective 2: By the end of 2020, information from surveillance data, in the form of fact sheets, presentations, and/or reports will be disseminated to 500 appropriate stakeholders.

Activities
1. Through 2020, continue to evaluate suicide data publications as to their usefulness in helping college and university administrators, local health districts, and community-based organizations implement suicide prevention strategies.
2. Through 2020, ensure capacity for the production and dissemination of suicide data publications.
3. Through 2020, identify and target surveillance data for specific audiences (e.g., policy makers, schools, local health departments, agencies serving at-risk populations, etc.)
4. Through 2020, improve the availability and accessibility of surveillance data for specific audiences (e.g., policymakers, schools, local health departments, etc.)
5. Through 2020, disseminate at least five suicide fact sheets.

Objective 3: By the end of 2020, continue to carry out and expand at least five best practice/evidence based strategies for addressing suicide in Utah.

Activities
1. By 2020, continue to promote efforts to reduce access to lethal means and methods of self-harm (including firearms, drugs, and poisons) through distribution of at least 5,000 firearm locks and brochures and through promoting at least 10 messages relating to means restriction.
2. Through 2020, continue to support at least 2 existing conferences that specifically address suicide; and promote/support opportunities for 2 additional Utah conferences to address evidence-based suicide prevention, intervention, and postvention strategies.
3. Through 2020, continue to support and expand implementation of best practice suicide prevention and postvention programs being offered throughout the state, such as QPR, safeTALK, Mental Health First Aid, ASIST, Signs of Suicide, More Than Sad and other programs created or supported by AFSP, Connect Suicide Postvention, etc., to reach at least 10,000 more Utahans by 2020.

4. By 2020, identify and increase implementation of 1 universal, primary prevention strategies for suicide prevention, that focus on resiliency, social support and connectedness, problem-solving skills, and other protective factors, such as the Good Behavior Game.
5. Through 2020, continue to identify and implement at least one program or strategy such as Man Therapy that particularly target working-aged males, which is the highest risk group for suicide death in Utah.
6. Through 2020, provide at least 3 evidence-based training and tools to behavioral health providers to increase their ability to effectively assess suicide risk, implement appropriate triage, counsel on reducing access to lethal means, engage the client in safety planning, and provide ongoing trauma-informed treatment in a manner that promotes healing and recovery.
18. Through 2020, educate universities on two suicide prevention initiatives that they can adopt at the school level. Through 2020, five implementing agencies will provide adequate staffing and resources, including budget, facilities, staff development, and time to implement suicide prevention programs that effect youth.
19. Through 2020, continue to seek out additional funding and resources to implement suicide prevention activities at all levels by applying for at least three grants that would benefit the entire state.
20. Through 2020, define five areas of focus for the role of public health in suicide prevention and increase the number of public health partners that are active in suicide prevention activities by 10%.
21. Through 2020, continue statewide collaboration to successfully implement at least 80% of the activities and recommendations of the Utah Suicide Prevention Plan.
22. Through 2020, continue to promote at least 5 suicide public awareness events sponsored by organizations such as NAMI Utah, Utah Chapter of the Mental Health Association, and the American Foundation for Suicide Prevention.
23. By 2020, identify at least 2 systems and agencies that can increase evaluation of the effectiveness and efficiency of the suicide prevention programs and interventions that are available in Utah, and complete at least 2 evaluation projects.
24. By 2012, implement policy in at least three school districts that designates a person with responsibility for coordinating safety activities at school and promoting a school climate that demonstrates respect, support, and caring that does not tolerate harassment or bullying.
25. Through 2020, 50% of schools will develop and implement written school policies (regarding substance abuse, bullying, violence, suicide crises or interventions, suicide postvention, etc.) in addition to disciplinary policies that are implemented consistently.
26. Through 2020, increase access to two suicide prevention programs and two mental health or suicide prevention resources in rural and frontier areas of the state that target resource and prevention gaps as identified by local coalitions and agencies.
27. Through 2020, continue to promote suicide public awareness events sponsored by organizations such as NAMI Utah, Utah Chapter of the Mental Health Association, and the American Foundation for Suicide Prevention. .

Objective 4: By the end of 2020, continue to update and implement at least two training guides/materials for health care providers, the media, clergy, or other identified groups that address suicide risk factors, treatment for suicidal thoughts, and reporting suicides.

Activities
1. By 2020, develop or adapt two guides or other materials that focus on identifying persons at risk of suicide, available treatment programs, and/or how to report suicides.
2. By 2020, update existing "pocket card" for reporting on violent deaths. Disseminate pocket card and train at least 50 Utah investigators and medical examiners in comprehensive interviewing techniques and reporting needs in order to improve quality of data gathered for violent deaths and suicides.
3. By 2020, define minimum course objectives addressing suicide risk and protective factors for health care provider and counseling training/graduate programs; and share with at least five relevant agencies.
4. Through 2020, continue to educate, support, and involve family members regarding risk and protective factors for suicide, warning signs of suicide, and resources, using at least 20 research-informed media messages.
5. Through 2020, train five additional local media representatives to promote accurate, responsible, and hopeful representation of suicidal behaviors, mental illness, and related issues in compliance with national reporting guidelines and Connect Suicide Postvention guidelines Increase the percentage of messages that provide positive narratives about resilience, recovery, treatment, and suicide prevention.
6. Through 2020, continue to train at least 20 agencies' educational staff, healthcare providers, aging services, faith-based organizations, call centers, justice system professionals, workplaces, and law enforcement officers on identifying and responding to a person in mental health crisis and/or at risk for suicide. Apply for and provide Continuing Education Units to at least two classes of professionals to incentivize professional development regarding suicide prevention topics.
7. Through 2020, continue to support all existing services to survivors of suicide loss, identify and increase at least one resource in rural areas for survivors of suicide loss, and investigate ways to increase outreach to families and youth after a suicide.
8. By 2020, pilot and evaluate at least one support group for suicide attempt survivors in Utah.
9. Through 2020, provide resources such as counseling on reducing access to lethal means, safety planning, and coping skills to teenagers who have attempted suicide through school counselors, emergency rooms, and behavioral health providers.
10. By 2020, investigate and pilot 2 evidence-based ways to provide support and care to clinicians, first responders, and medical professionals when a patient under their care dies by suicide.

Objective 5: By the end of 2020, access to mental health and substance abuse services will increase by 10%.

Activities

10. By 2020, define and increase use of guidelines for mental health screening (including substance abuse) and referral of students in at least one university or college.
11. By 2020, implement guidelines for mental health assessment and treatment for suicidal individuals from adult and juvenile incarcerated populations in at least 5 facilities.
12. Through 2020, assess access to mental health care, and improve access to mental health care for uninsured and non-Medicaid youth population by ensuring that at least 50% of this population has access to mental health and psychiatric services.
13. By 2020, collect current information for mental health and crisis services in each county in Utah and annually update this resource list on the Utah Suicide Prevention Coalition and Utah Department of Health websites.
14. By 2020, distribute the policies and procedures of the UNI crisis response model to all local mental health authorities in Utah to provide them with strategies to increase the quality, capacity, and mobility of their 24-hour crisis care.
15. By 2020, develop and disseminate a protocol/guide based on the UNI Receiving Center and Wellness Recovery Center, to creating crisis and recovery centers as an alternative to Emergency Department care when appropriate, or as a residential level of care that facilitates return to community outpatient care (Objective 8.8 in the National Strategy).
16. Through 2020, conduct a literature review to create a best practice protocol for continuity of care, and provide training and information to at least 15 health and behavioral health agencies.
17. Through 2020, assess how many healthcare providers are currently engaged in the Zero Suicide Initiative and educate providers about the benefits and resources that the initiative provides, to improve the policies and infrastructure of the healthcare and behavioral health systems at all stages of suicide prevention and intervention, and highlight successful systems and programs.
18. Educate physicians on suicide risk assessment and increase the number of health systems using evidence based screening tools for depression and suicide by one.

Implementing Organizations

- Faith-based organizations
- Juvenile and Adult Corrections
- Local colleges and universities
- National Alliance on Mental Illness – Utah
- American Foundation for Suicide Prevention
- Utah Department of Health
  - Bureau of Maternal and Child Health
  - Violence and Injury Prevention Program

- Utah Department of Human Services
  - Division of Substance Abuse and Mental Health
- Utah's local health departments
- Utah's hospitals and healthcare providers
- Local non-profit organizations
- Local mental health providers

Evidence-based Interventions/Best Practices
- Community Trials Intervention To Reduce High-Risk Drinking
  http://www.pire.org/communitytrials/index.htm
- Emergency Department Means Restriction Education
  http://nrepp.samhsa.gov/ViewIntervention.aspx?id=15
- Emergency Room Intervention for Adolescent Females
  http://chipts.ucla.edu/interventions/manuals/interer.html
- Seeking Safety http://www.seekingsafety.org
- United States Air Force Suicide Prevention Program
  http://nrepp.samhsa.gov/ViewIntervention.aspx?id=121
- Challenging College Alcohol Abuse http://www.socialnorms.campushealth.net,
  http://www.health.arizona.edu
- Coping With Work and Family Stress
  http://www.theconsultationcenter.org/index.php?/coping-with-work-a-family-stress.html
- **Suicide Prevention Resource Center Best Practices Registry**
  //www.sprc.org/bpr/section-i-evidence-based-programs
- **Suicide Prevention Resource Center Expert/Consensus Statements**
  http://www.sprc.org/bpr/section-ii-expertconsensus-statements
- **American Foundation for Suicide Prevention Education and Prevention Programs**
  https://www.afsp.org/preventing-suicide/our-education-and-prevention-programs
- www.reportingonsuicide.org

Ages 25-64

Family Violence

Overview

Sexual Assault. Sexual violence in Utah is a serious public health problem affecting thousands of residents each year. Studies in Utah indicate that one in eight women and one in 50 men will experience rape in their lifetimes[71] and nearly one in three women will experience some form of sexual violence during their lives.[72] Additionally, a national study showed one in four women and one in six men reported being a victim of child sexual abuse.[73] For the most part, sexual assault affects Utah's younger population.

Utah ranks 19th in the nation for reported forcible rapes.[74] Rape is the only violent crime in Utah that is higher than the national average. In a state where other violent crimes such as, homicide, robbery or aggravated assault, is historically half to three times lower than the national average, this is of concern. Since 2000, Utah's reported rape rate has been significantly higher than the U.S. reported rape rate. In 2014, Utah's reported rape rate was 67.7 per 100,000 females and the U.S. rate was 51.9 per 100,000 females (Figure X).[75]

Figure X

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[71] *Utah Department of Health. (2008).* Utah Health Status Update: Sexual Violence. *April 2008.*

[72] *Haddon, M., & Christenson, J (2005).* Rape in Utah. *Utah Commission on Criminal and Juvenile Justice.*
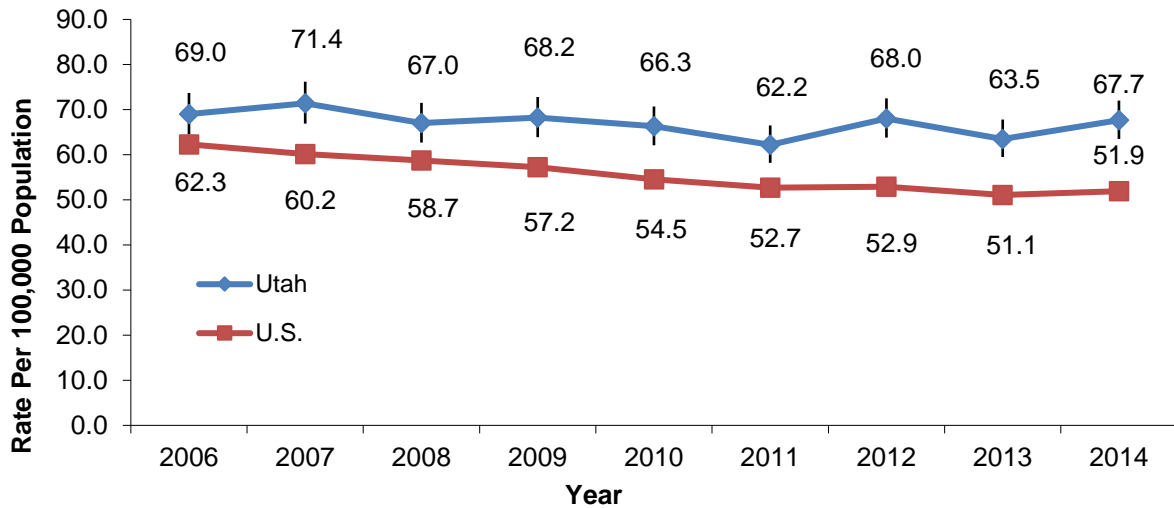
[73] *Dube, S.R., Anda, R.F., Whitfield, C.L., et al. (2005). Long-term consequences of childhood sexual abuse by gender of victim. American Journal of Preventive Medicine, 28, 430-438.*

[74] *U.S. Department of Justice. Federal Bureau of Investigation, (2008) Crime in the United States, 2007.* http://www.fbi.gov/ucr/cius2007/ *Accessed April 2009.*

[75] *IBIS.*

Rate Of Reported Rapes by Year, Utah And U.S. Females, 2006-2014

Rate Per 100,000 Population

Year	Utah	U.S.
2006	69.0	62.3
2007	71.4	60.2
2008	67.0	58.7
2009	68.2	57.2
2010	66.3	54.5
2011	62.2	52.7
2012	68.0	52.9
2013	63.5	51.1
2014	67.7	51.9

Data, Surveillance and Costs

Geographic Data

Sexual Assault. According to the 2006 Utah BRFSS survey, there were no significant differences in lifetime prevalence of rape or attempted rape by locality. However, the residential county of the person at the time of the survey doesn't necessarily indicate the residential county of where the rape or attempted rape occurred. Using Uniform Crime Report data, the following counties have significantly higher reported rape rates than the state rate:

Location	Rate per 100,000 population
State	72
Uintah	101
Carbon	98
Salt Lake	95
Tooele	89
Weber	80

The following counties have significantly lower reported rape rates than the state rate:

Location	Rate per 100,000 population
State	72
Wasatch⍰	22
Sanpete	31
San Juan	39

Utah	47
Washington	53
Cache	54
Iron	55
Davis	55

The following counties had too few reported rapes to meet UDOH standard for reliability: Beaver, Emery, Rich. The following counties did not have any reported rapes: Daggett, Garfield, Morgan, Piute, Wayne.

Age and Sex

Sexual Assault. According to the 2006 Utah BRFSS, females have a significantly higher prevalence of rape or attempted rape than males (12% and 2%, respectively).[76] Among female victims who experienced rape or attempted rape, 99 percent were victimized by a male.[77] In the 2007 Rape in Utah Survey, 95 percent reported that the sexual assault was committed by a male.[78]

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[76] *Utah Department of Public Safety, (2008). Crime Statistics for the State of Utah. http://publicsafety.utah.gov/bci/crimestatistics.html Accessed February 2008.*
[77] *Haddon, M., & Christenson, J (2005).* Rape in Utah. *Utah Commission on Criminal and Juvenile Justice.*
[78] *Mitchell, C., & Peterson, B., (2007).* Rape in Utah, 2007. *Utah Commission on Criminal and Juvenile Justice.*

Domestic Violence

Domestic violence is a preventable public health problem that encompasses many forms of abuse that could be physical, sexual, or emotional to ongoing battering to death such as homicide or suicide. There are nearly 7.7 million injuries and 1,200 deaths nationwide every year due to intimate partner violence, a type of domestic violence which only includes abuse that occurs between current and former spouses and dating partners. [79]

On average, domestic violence-related homicides account for over 40.0% of adult homicides in Utah from 2000-2011 (Figure X).[80] From 2000-2011, there were a total of 226 domestic violence-related homicides, an average of 19 deaths per year.

Figure X

Percentage Of Homicides By Homicide Type, Utah Adults, 2000-2011
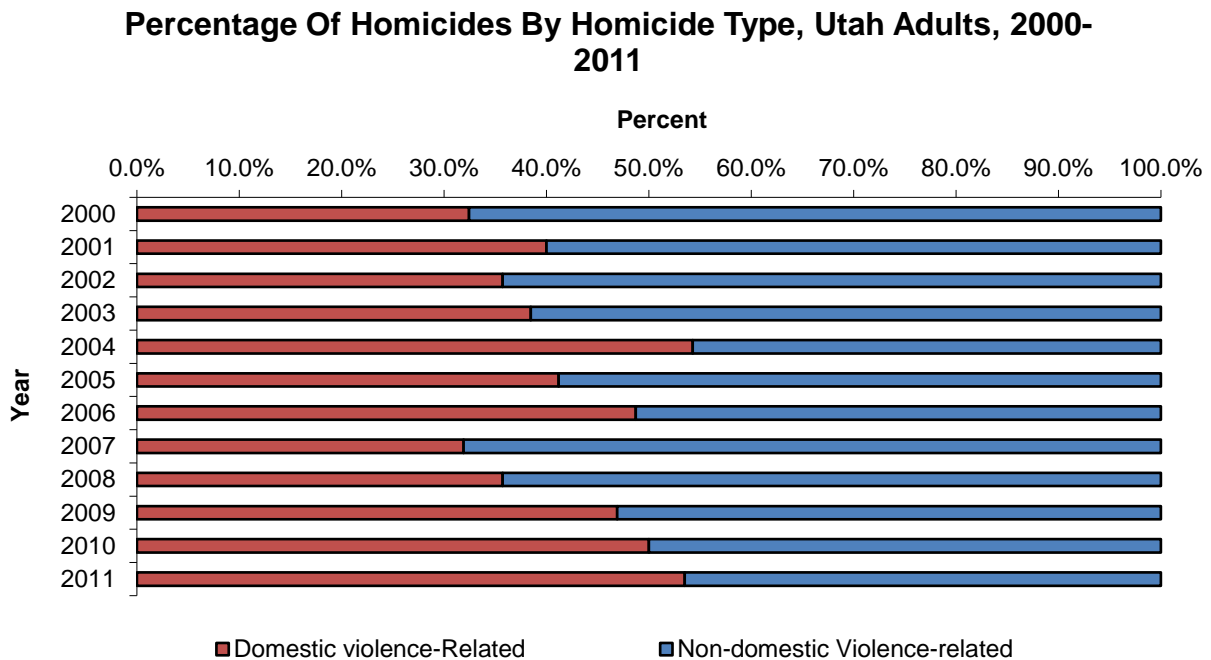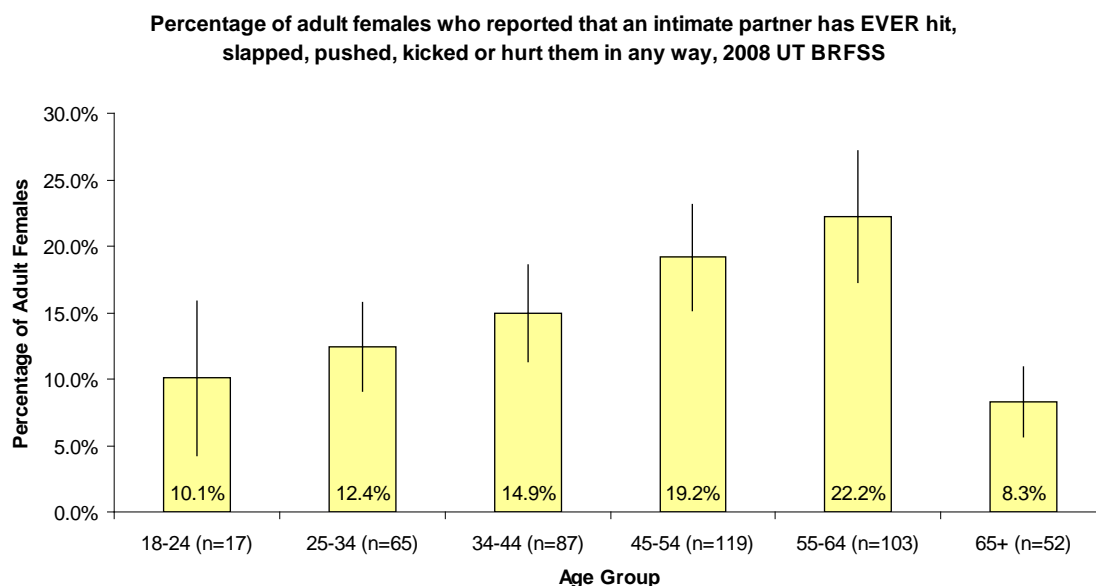
Domestic Violence.

Age and Sex

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[79] IBIS
[80] Utah Domestic and sexual violence report, 2015

Family Violence. According to the 2008 Utah Behavioral Risk Factor Surveillance System, 14.2% females reported that they have been hit, slapped, pushed, kicked, or hurt in any way by an intimate partner in their lifetime (Figure X). Of the females who reported intimate partner violence (IPV), 7.8% indicated that they have experienced IPV is the past 12 months. Of these females, 39.1% of the perpetrators were husbands or a male live-in partner, 27.2% were former husbands or former live-in partners, and 25.7% were former boyfriends.

The Youth Risk Behavior Surveillance System (YRBSS) surveys 9th through 12th grade students every two years. In 2011, it was found that 11.8% of Utah high school student respondents reported that they were hit, slapped, or physically hurt on purpose by a boyfriend or girlfriend during the 12 months prior to the survey.

Percentage of adult females who reported that an intimate partner has EVER hit, slapped, pushed, kicked or hurt them in any way, 2008 UT BRFSS

Males have a significantly higher domestic violence-related homicide perpetrator rate than females (1.6 and .3 per 100,000 adults, respectively).[81] There was not a significant difference among domestic violence-related homicide victims by gender and age group.[82]

Males also have a significantly higher domestic violence-related suicide rate than females (4.5 and 0.6 per 100,000 adults, respectively).[83] There were no significant differences among age groups in domestic violence-related suicide victims, homicide victims and homicide perpetrators.[84]

Healthy People 2020 Objectives

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[81] *2000-2002 Domestic Violence Fatalities in Utah Report*
[82] *2000-2002 Domestic Violence Fatalities in Utah Report*
[83] *2000-2002 Domestic Violence Fatalities in Utah Report*
[84] *2000-2002 Domestic Violence Fatalities in Utah Report, 2005-2006 UTVDRS*

- **IVP-31**   Reduce violence by current or former intimate partners
- **IVP-32**   Reduce sexual violence
- **IVP-42**   Reduce children's exposure to violence

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By the end of 2015, sexual violence prevention coalitions will be formed in Tooele, Uintah, and Carbon Counties.

Activities

1. By 2012, identify key leaders and groups within these counties and work with them to establish sexual violence prevention coalitions.
2. By 2013, conduct community needs assessments in each of these counties to determine the needs and conditions that must be addressed in order to prevent sexual violence.
3. By 2014, provide training and technical assistance to support the coalitions develop prevention initiatives.
4. By 2015, invite disparate communities to participate in the coalitions and the Family and Sexual Violence Prevention Alliance.

Objective 2: By the end of 2015, build the understanding of family violence through collection of data on protective factors and risk factors.

Activities

1. By 2012, conduct community needs assessments in each of Utah's counties to determine the needs and conditions that must be addressed in order to prevent family violence.
2. By 2013, conduct surveillance on sexual violence (SV) and its relationship to adverse childhood experiences (ACE) through the SV and ACE modules of the BRFSS.
3. By 2013, disseminate the findings of the SV and ACE modules.
4. By 2014, publish an analysis of the costs of sexual violence in Utah, using the methodology published by the Minnesota Department of Health.
5. Through 2015, continue to encourage and support research into identifying the prevalence and dynamics of family violence in Utah.
6. Through 2015, improve data collection around family violence perpetration and victimization.

Implementing Organizations
- Local colleges and universities
- Utah Department of Health
    - Violence and Injury Prevention Program
- Utah's Local Health Departments
- Utah Coalition Against Sexual Assault
- Utah Domestic Violence Coalition
- Utah Commission on Criminal and Juvenile Justice
- Utah Sexual Violence Council

**Evidence-based Interventions/Best Practices**

Motor Vehicle Crashes

Overview

Motor vehicle crashes[85] (MVC) are the second leading cause of injury death, behind poisoning, for all ages in Utah. Motor vehicle crashes may include occupants in motor vehicles (driver and passengers), motorcyclists, bicyclists, pedestrians, and All Terrain Vehicle/Off Highway Vehicles (ATV/OHV).

Utah's rate of MVC traffic[86] occupants[87] deaths decreased since 2006 (Figure X).
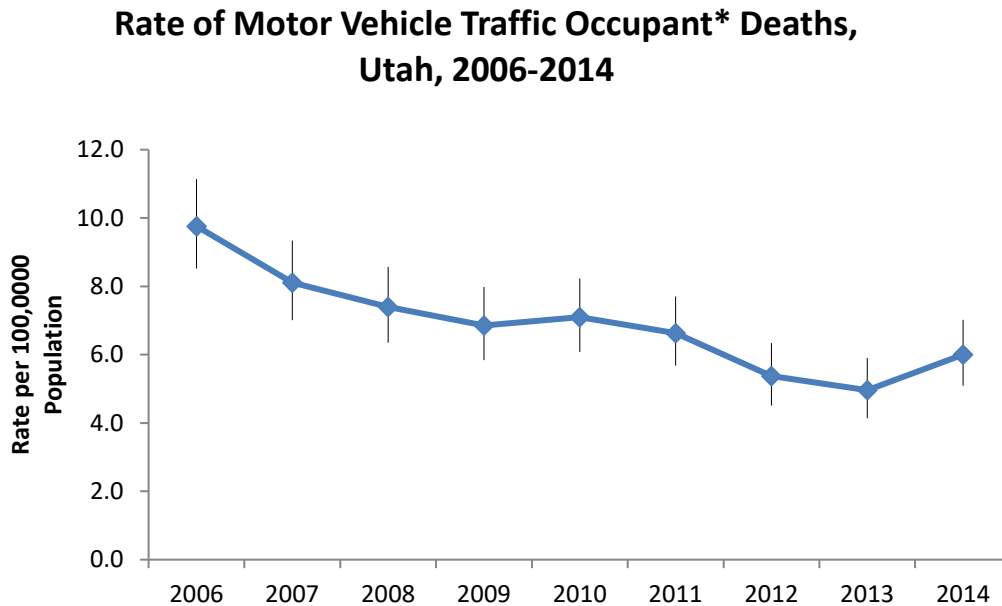
Figure X

Rate of Motor Vehicle Traffic Occupant* Deaths, Utah, 2006-2014

*Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators

However, motorcyclist[88] , bicyclist[89] , pedestrian[90] , and ATV/OHV[91] deaths have remained fairly consistent during this time (Figure X).

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[85] *Motor Vehicle Crashes include eight indicators on IBIS: 1) MV traffic-occupant injured, 2) MV traffic-motorcyclist injured, 3) MV traffic-pedal cyclist injured, 4) MV traffic-pedestrian injured, 5) MV traffic-other and unspecified, 6) pedal cyclist MV non-traffic and other, 7) pedestrian MV non-traffic and other, and 8) other MV non-traffic and other.*
[86] *MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified.*
[87] *Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators.*
[88] *Motorcyclists include those in the MV traffic-motorcyclist injured indicator.*
[89] *Bicyclists include those in the MV traffic-pedal cyclist injured and pedal cyclist MV non-traffic and other indicators.*

Figure X

Rate Of Other Motor Vehicle Deaths by Type, Utah, 2006-2014

*Due to the small numbers, results should be interpreted with caution.

Since 2006, Utah has had a lower MVC traffic death rate than the U.S. (Figure X).[91]

Figure X

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[90] *Pedestrians include those in the MV traffic-pedestrian injured and pedestrian MV non-traffic and other indicators.*
[91] *ATV/OHV deaths include those in other MV non-traffic and other indicator.*
[92] *WISQARS*

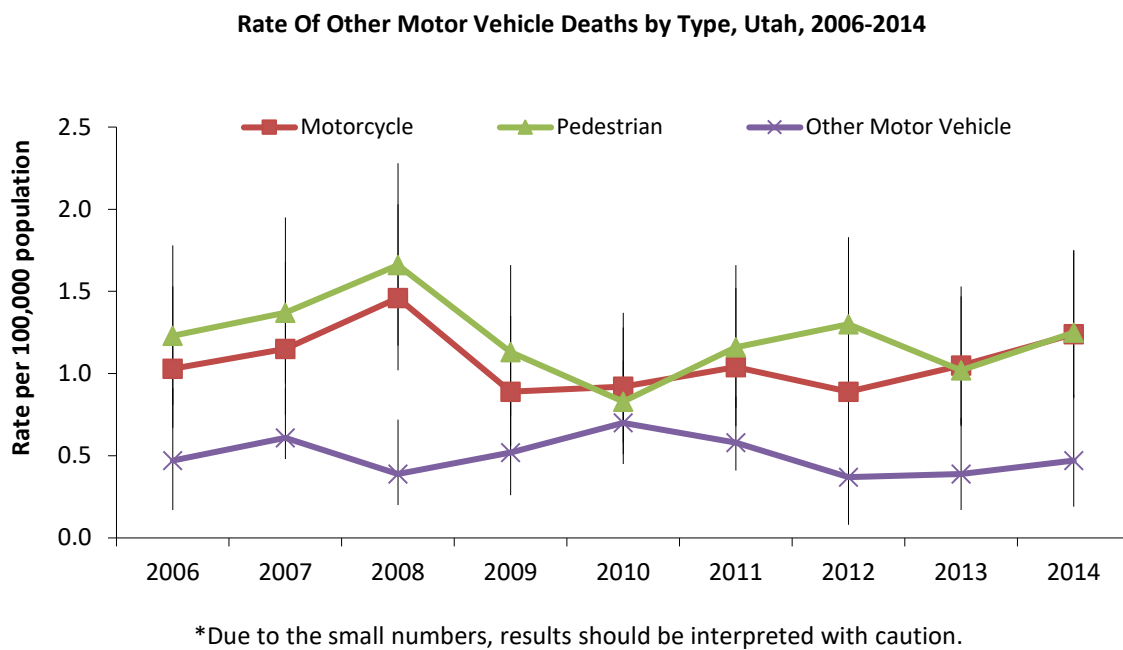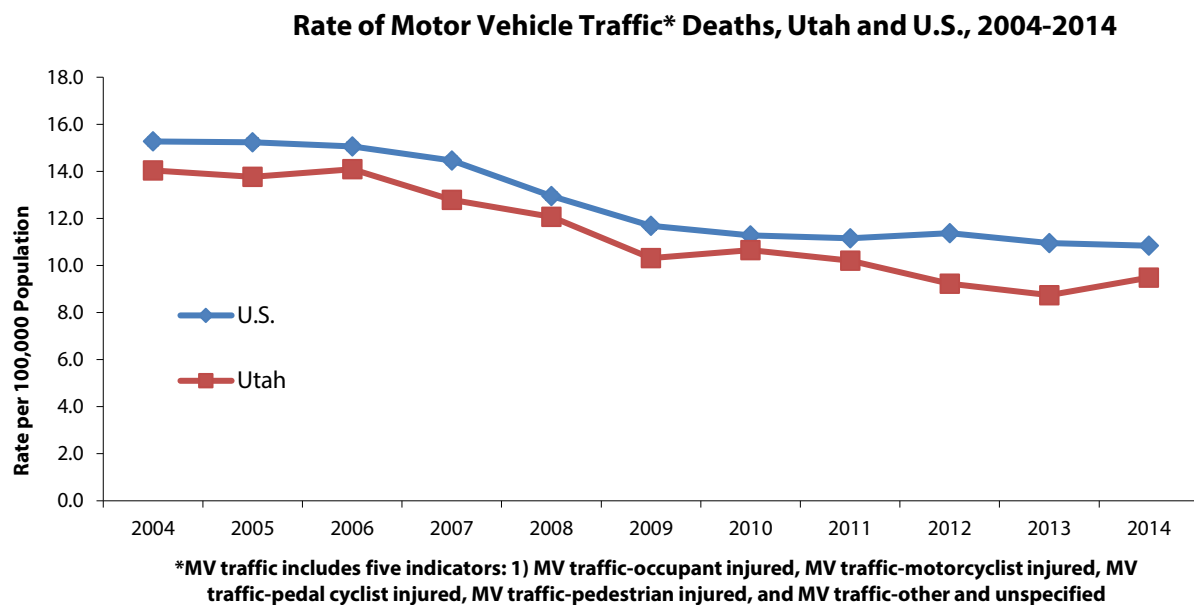**Rate of Motor Vehicle Traffic* Deaths, Utah and U.S., 2004-2014**

*MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified

In 2014, Utah's MVC traffic death rate for all ages was 8.16 per 100,000 population compared to the U.S. age-adjusted MVC death rate of 10.58 per 100,000 population. [92]

Data, Surveillance and Costs

Geographic

In 2014, Weber-Morgan HD had the highest MVC traffic ED visit rate for all ages at 73 per 10,000 population among local health districts. Tooele HD had the highest MVC traffic hospitalization rate for all ages at 6.01 per 10,000 population while Tricounty HD had the highest MVC traffic death rate for all ages at 25.7 per 100,000 population among local health districts.

Other HDs and small areas with significantly higher and lower MVC rates than the state rate can be found in Appendix X.

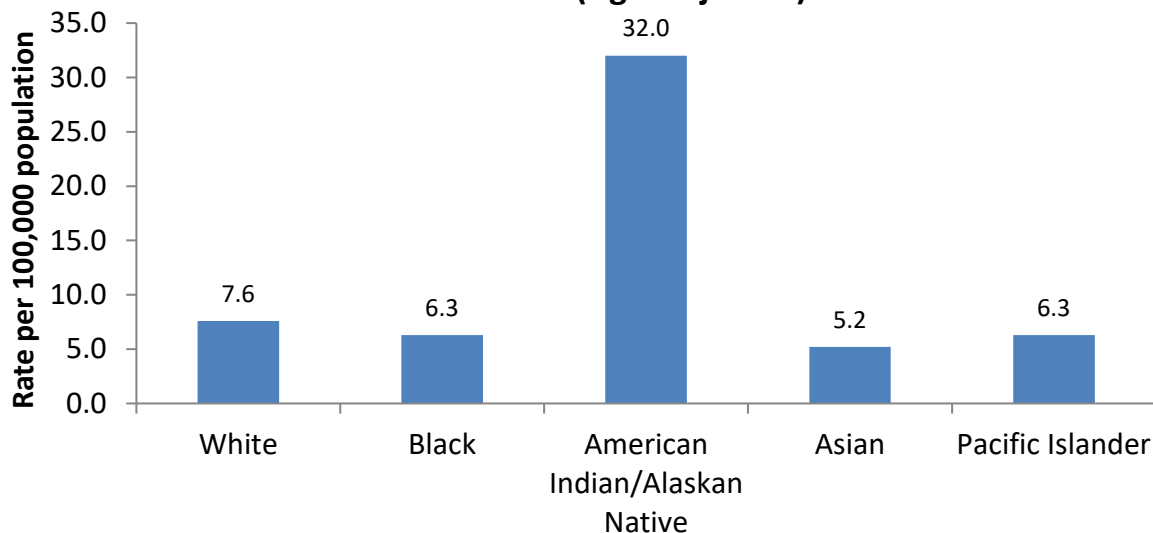**Race and Ethnicity[93]**

From 2010-2014, American Indians/Alaskan Natives (32.0 per 100,000 population) had a higher rate of MVC traffic deaths than White persons (7.6 per 100,000 population) and Black persons (6.3 per 100,000 population) (Figure X). However, statistical significance could not be calculated because case-level data was not available.

Figure X

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[93] *WISQARS, data years 2001-2005*

Rate of Motor Vehicle CrashTraffic Deaths by Race, Utah, 2010-2014 (Age-Adjusted)

Bar chart showing "Rate per 100,000 population" on the y-axis (0.0 to 35.0):
- White: 7.6
- Black: 6.3
- American Indian/Alaskan Native: 32.0
- Asian: 5.2
- Pacific Islander: 6.3

Healthy People 2020 Objectives
- IVP-14   Reduce nonfatal motor vehicle crash-related injuries
- IVP-15   Increase use of safety belts
- IVP-16   Increase age-appropriate vehicle restraint system use in children
- IVP-18   Reduce pedestrian deaths on public roads
- IVP-19   Reduce nonfatal pedestrian injuries on public roads
- IVP-20   Reduce pedal cyclist deaths on public roads
- IVP-21   Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders
- IVP-22   Increase the proportion of motorcycle operators and passengers using helmets

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: Develop and/or adapt an existing safe driving educational campaign for adults 25-64.

Activities
1. By end of 2020, expand and/or adapt existing materials for parents/guardians on how to teach teens safe driving.

2. By end of 2020, expand a course for parents/guardians of teens (ages 15-19) in driver education programs.
3. By 2017, pass legislation requiring parents/guardians take the parent/guardian course for teen drivers prior to their child receiving a driver's license.
4. By 2016, explore feasibility of a motorcycle helmet law.
5. By 2016, personalize messages to communities based on local stories and local data.
6. Through 2020, continue to educate families attending car seat checks on all aspects of safe driving.
7. Through 2020, maintain consistent messaging with the Zero Fatalities campaign but recycle messages to keep them fresh.

Objective 2: Enact policies/legislation regarding motor vehicle safety.

Activities
1. Yearly, through 2020, promote workplace policies prohibiting employees from using cell phones while driving on company business.
2. By 2020, pass legislation banning hands-free use of cell phones while driving for all ages.
3. Through 2020, evaluate and support policies/legislation regarding distracted driving, impaired driving, drowsy driving, and aggressive driving.
4. By end of 2020, pass legislation requiring drivers to retake the written driving exam at specified intervals.
5. By 2018, complete an evaluation of the Primary Seatbelt Law.
6. By 2019, work with stakeholders to help make the Primary Seatbelt Law permanent.
7. Through 2020, provide at least two data-driven fact sheets on MVC-related legislation to advocates, Utah Legislature, and other stakeholders.
8. Through 2020, increase education to elected officials and policy makers on motor vehicle-related trends and challenges through a minimum of two fact sheets, briefings, or other educational activities.
9. Through 2020, continue to enforce handheld cell-phone-use-while-driving ban law.

Objective 3: Continue surveillance of MVC injuries and deaths.

Activities
1. Through 2020, ensure capacity for the production and dissemination of motor vehicle crash-related publications.
2. Through 2020, collaborate with the Utah Highway Safety Office to identify and target surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
3. Through 2020, maintain publicly accessible data query system through the Indicator Based Information System for Public Health (IBIS-PH).

4. Through 2020, leverage existing surveillance systems and data sources to collect motor vehicle crash-related data.
   a. Driving behaviors through BRFSS
   b. Impaired driving, specifically opioid intoxication in fatal crashes (UTVDRS)
   c. General crash fatality data FARS/NVDRS
7. Through 2020, develop and update fact sheets and data reports on an annual basis.

Implementing Organizations
- American Automobile Association (AAA), Utah chapter
- Insurance companies
- Law enforcement agencies
- Safe Kids Utah
- Utah's 12 Local Health Departments
- Utah Department of Health
  - Violence and Injury Prevention Program
- Utah Department of Transportation
- Utah Department of Public Safety
  - Utah Highway Safety Office
- Utah Safety Council
- Zero Fatalities campaign

Evidence-based Interventions/Best Practices
- Zero Fatalities http://ut.zerofatalities.com/

Poisoning

Overview

Drug poisoning deaths are a preventable public health problem and have outpaced deaths due to firearms, falls, and motor vehicle crashes in Utah. Every month, 49 Utahns die as a result of a drug poisoning, 82.3% of which are accidental or of undetermined intent, and of these, 74.8% involve opioids. Utah is particularly affected by prescription opioids, which are responsible for many of the drug poisoning deaths in Utah.

In 2013, the poison death rate for Utah was 23.25 per 100,000 population and is significantly higher than the U.S. rate of 15.2 per 100,000 population. In 2013, Utah ranked 5th in the U.S. for drug poisoning deaths.[94]

Figure X
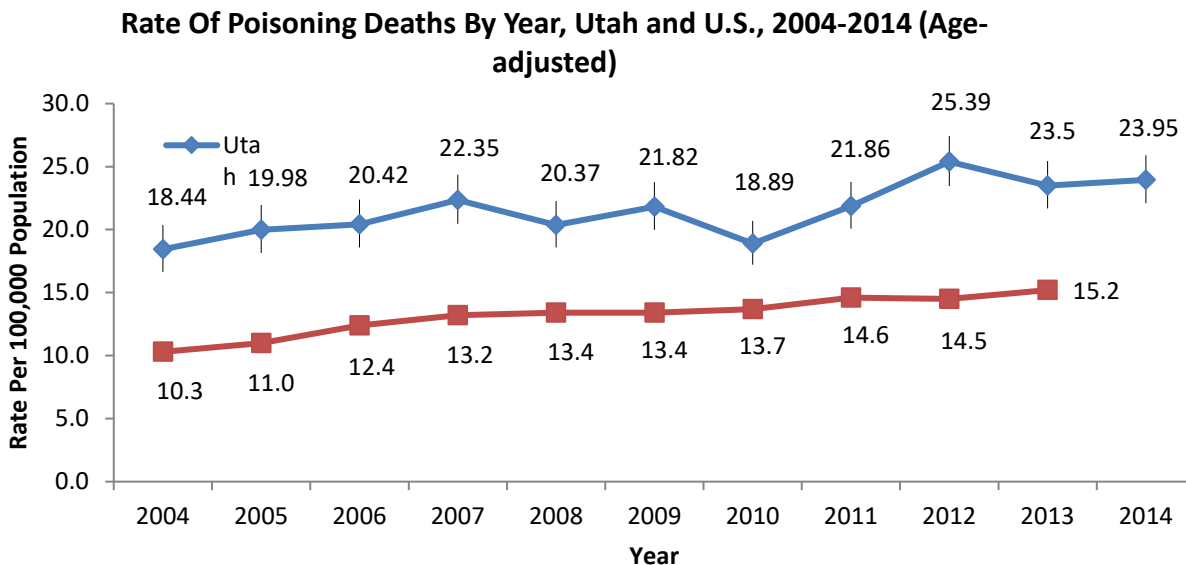
Rate Of Poisoning Deaths By Year, Utah and U.S., 2004-2014 (Age-adjusted)

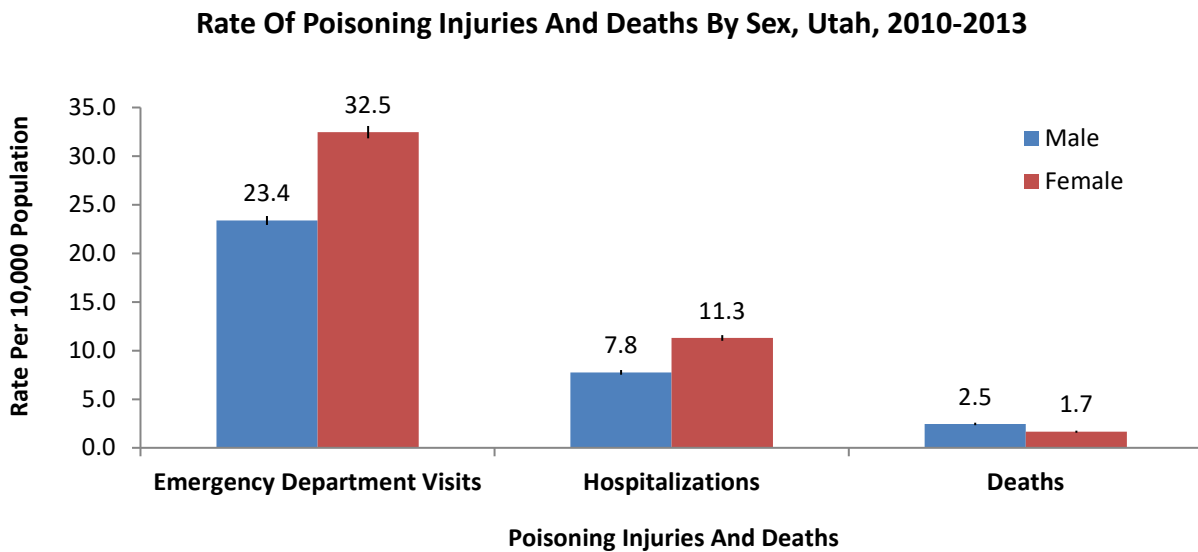
Data, Surveillance and Costs

Age and Sex

Females have significantly higher poisoned visit and hospitalization rates compared to males. However, males have significantly higher poison death rates compared to females (2.5 and 1.7 per 10,000 population) (Figure X).

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[94] IBIS *Important Facts for Drug Overdose and Poisoning*

Figure X

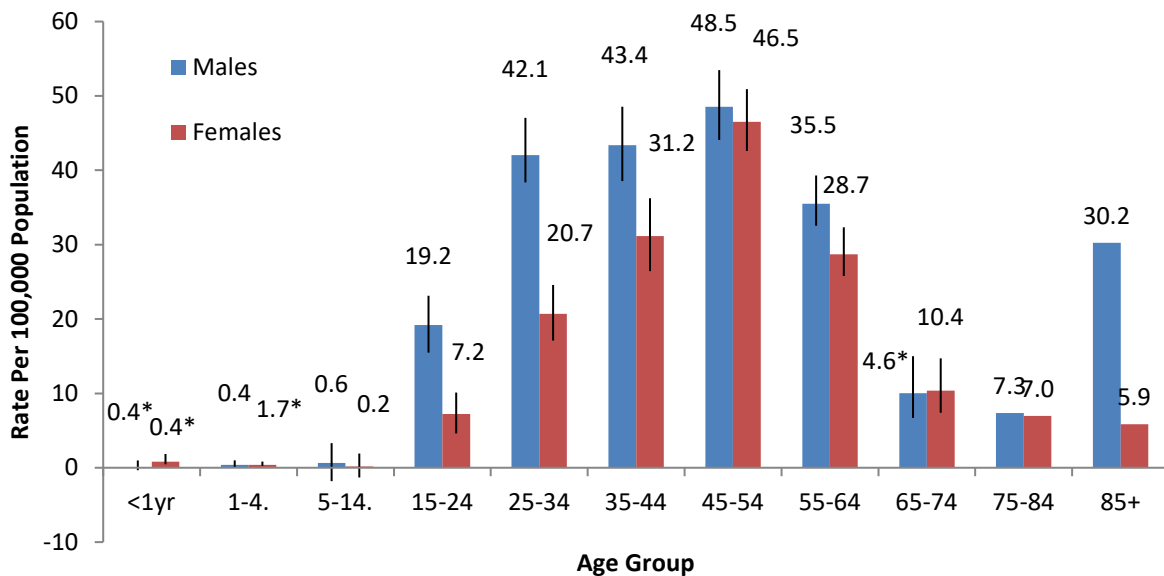**Rate Of Poisoning Injuries And Deaths By Sex, Utah, 2010-2013**

When broken down by age group, 15-17 year old males and females (32.8 and 65.4 per 10,000 population) had the highest poison ED visit rates among age groups. For poison hospitalizations, 18-24 year old males (9.2 per 10,000 population) and 35-44 year old females (14.8 per 10,000 population) had the highest rates among age groups.

Persons 45-54 had the highest poison death rate among males and females (48.5 and 46.5 per 100,000 population). Males 18-44 had significantly higher poison-related death rates compared to females (Figure X).

Figure X

Rate Of Poison-related Deaths By Age Group And Sex, Utah, 2010-2014

Prescription Opioid Deaths

Prescription pain medications underlie many Utah poisoning deaths. The majority of the increase in poison deaths occurred as a result of overdose of non-illicit drugs, which includes primarily prescription medications. In 2009, approximately 80% of the unintentional and undetermined poison deaths in Utah were due to prescription pain relievers, such as oxycodone, methadone, hydrocodone, and morphine.

In 2014, 15.6% of Utah poisoning deaths were of undetermined intent, 15.8% were self-inflicted, 68.4% were unintentional and less than 1% were homicides[45].

From 2012 to 2014, males (25.3 per 100,000 population) had a significantly higher age-adjusted drug poisoning death rate compared to females (18.7 per 100,000 population).

Healthy People 2020 Objectives

- IVP-9   Prevent an increase in the rate of poisoning deaths
- IVP-10   Prevent an increase in the rate of nonfatal poisonings
- MPS-2   (Developmental) Increase the safe and effective treatment of pain
- SA-12   Reduce drug-induced deaths
- SA-19   Reduce the past-year nonmedical use of prescription drugs

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on

implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Objective 1: By the end of 2020, at least one existing surveillance system will be improved to adequately monitor prescription drug overdose deaths in Utah.

Activities
1. By 2016, identify new primary users of information, assess their needs, and prioritize according to the results of the assessment.
2. By 2016, explore the Utah Violent Death Reporting System for its usefulness in monitoring prescription drug overdose deaths in Utah.
3. By 2016, develop a list of data needs that are not covered by existing data sources.
4. By 2013, implement opportunities to add prescription drug overdose fatality components to at least one existing data collection system (e.g., UTVDRS) to gather more complete information about specialty populations at risk for prescription drug overdoses, including treatment data and criminal records in order to close gaps in prescription drug overdose death data collection.
5. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate prescription drug overdose fatality data.

Objective 2: By the end of 2015, information from surveillance data will be disseminated to appropriate stakeholders.

Activities
1. By 2016, identify and target surveillance data for specific audiences (e.g., policy makers, local health departments, etc.)
2. By 2017, disseminate lessons learned from the Utah Prescription Drug Overdose Program.
3. By 2018, evaluate data publications as to their usefulness in helping local health districts and community-based organizations implement poisoning prevention strategies.
4. Through 2020, ensure capacity for the production and dissemination of prescription drug overdose data publications.
5. Through 2020, disseminate at least three prescription drug overdose fact sheets.

Objective 3: By the end of 2015, more than half of Utah's general population will recognize that prescription drug overdose is a preventable public health problem.

Activities
1. By 2016, identify baseline measure using responses to the Use Only As Directed statewide survey
2. By 2016, expand training to address prescription drug overdoses.

3. By 2017, compile a summary report on progress made regarding the Prescription Drug Overdose Program activities.
4. By 2018, implement evidence-based substance abuse prevention programs that target persons that are identified as being at risk of death or harm from prescription pain medication overdose.
5. Through 2020, promote efforts to educate the public on proper use, storage, and disposal of prescription pain medications via media outlets.
6. Through 2020, continue statewide collaboration to implement the activities and recommendations of the Utah Pharmaceutical Drug Crime Project.
7. Through 2020, promote prescription drug overdose public awareness events sponsored by organizations such as Utah Pharmaceutical Drug Community Project, Division of Substance Abuse and Mental Health, Department of Environmental Quality, and Drug Enforcement Agency.

Objective 4: By the end of 2015, increase the number of trained providers on proper prescribing of opioids including screening, treatment, and monitoring by 50%.

Activities
1. By 2012, meet with Division of Occupational and Professional Licensing to determine a baseline measure for this objective.
2. By 2012, pass legislation requiring CME for physicians prescribing opioids.
3. By 2012, define minimum course objectives for prescribing providers. By 2013, ensure that options for CME on proper prescribing of opioids are available to providers.
4. By 2014, review and revise Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain with any updated research findings.
5. Through 2015, provide support, grief counseling resources, and connections to community resources/opportunities to families who participate in the next of kin drug overdose death survey.
6. Through 2015, continue to disseminate the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain and continue to make CMEs available.
7. Through 2015, partner with the Division of Occupational and Professional Licensing to develop a tracking system of physicians who have been trained on the Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain.

Objective 5: By the end of 2015, enhance participation in an existing agency with mental health and substance abuse as their mission.

Activities
1. By 2012, strengthen partnership with the Utah Department of Human Services, Division of Substance Abuse and Mental Health as evidenced by a Memorandum of Understanding.

2. By 2012, define and implement guidelines for substance abuse and mental health screening and referral to at-risk populations (e.g., uninsured and non-Medicaid, students in universities and colleges, adult and juvenile incarcerated populations).
3. Through 2015, provide referrals for substance abuse and mental health services to the community.

> **Objective 6: By the end of 2015, increase utilization of options for proper disposal of prescription medications.**

Activities
1. Through 2015, educate the public on proper disposal of unused and expired medication.
2. Through 2015, educate public about locations for drop boxes and keep these locations updated at useonlyasdirected.org
3. Through 2015, support new legislation regarding options for disposal in other public locations.

Implementing Organizations
- American Academy of Family Physicians, Utah chapter
- Department of Environmental Quality
- Division of Occupational and Professional Licensing
- Drug Enforcement Agency
- Law Enforcement Agencies
- Local colleges and universities
- Utah Department of Health
    - Check Your Health
    - Prescription Pain Medication Management and Education Program
    - Violence and Injury Prevention Program
- Utah Department of Human Services
    - Division of Substance Abuse and Mental Health
- Utah's Local Health Departments
- Utah's Local Substance Abuse Authorities
- Utah Medical Association
- Utah National Alliance on Mental Illness
- Utah Nursing Association
- Utah Pharmacy Association
- Utah Pharmaceutical Drug Crime Project (UPDCP)
- Utah Poison Control Center
- Utah Psychiatrist Association

Evidence-based Interventions/Best Practices
- Celebrating Families http://www.celebratingfamilies.net

Objective 1: By the end of 2020, evaluate existing surveillance systems to adequately monitor and measure risk and protective factors for suicide, suicide deaths, and suicide attempts in Utah.

Activities

11. By 2020, continue to work with existing partners and identify additional users of information, assess their needs, and prioritize according to the results of the assessment.
12. By 2020, evaluate the Utah Violent Death Reporting System and the Behavioral Risk Factor Surveillance System for their usefulness in monitoring utilization of mental health and substance use services, risk and protective factors for suicide, suicide ideation, suicide deaths, and attempted suicides in Utah.
13. By 2018, develop a list of data needs that are not covered by existing data sources.
14. By 2020, add suicide components to existing data collection systems to gather more complete information about populations at risk for suicide, to screen for distress and dysfunction associated with mental illness, and to close gaps in suicide data collection.
15. By 2020, collaborate with partners such as Law Enforcement and the LGBT Committee of the Utah Suicide Prevention Coalition to determine and implement methods to collect, analyze, and interpret more comprehensive data relating to LGBT risk factors, suicide attempts, and death rates in Utah.
16. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate suicide data.
17. By 2020, organize and implement a Suicide Fatality Review Committee involving key partners, and regularly share recommendations from the committee with agencies in Utah.
18. By 2020, evaluate Parent Seminars on Youth Protection for feasibility, attendance, and effectiveness, and make recommendations for improvement if necessary.
19. By 2020, develop a Utah suicide prevention research agenda with comprehensive input from multiple stakeholders; then carry out at least one suicide prevention research/evaluation project and disseminate the results.
20. By 2020, identify ways to increase the tracking and coordination of statewide efforts in suicide prevention. By 2020, compile a summary report on progress made regarding the Utah Suicide Prevention Plan.

Objective 2: By the end of 2020, information from surveillance data, in the form of fact sheets, presentations, and/or reports will be disseminated to 500 appropriate stakeholders.

Activities

6. Through 2020, continue to evaluate suicide data publications as to their usefulness in helping local health districts, and community-based organizations implement suicide prevention strategies.
7. Through 2020, ensure capacity for the production and dissemination of suicide data publications.
8. Through 2020, identify and target surveillance data for specific audiences (e.g., policy makers, schools, local health departments, agencies serving at-risk populations, etc.)
9. Through 2020, improve the availability and accessibility of surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
10. Through 2020, disseminate at least five suicide fact sheets.

Objective 3: By the end of 2020, continue to carry out and expand at least five best practice/evidence based strategies for addressing suicide in Utah.

Activities

1. By 2020, continue to promote efforts to reduce access to lethal means and methods of self-harm (including firearms, drugs, and poisons) through distribution of at least 5,000 firearm locks and brochures and through promoting at least 10 messages relating to means restriction.
2. Through 2020, continue to support at least 2 existing conferences that specifically address suicide; and promote/support opportunities for 2 additional Utah conferences to address evidence-based suicide prevention, intervention, and postvention strategies.
3. Through 2020, continue to support and expand implementation of best practice suicide prevention and postvention programs being offered throughout the state, such as QPR, safeTALK, Mental Health First Aid, ASIST, Signs of Suicide, More Than Sad and other programs created or supported by AFSP, Connect Suicide Postvention, etc., to reach at least 10,000 more Utahans by 2020.
4. Through 2020, continue to identify and implement at least one program or strategy such as Man Therapy that particularly target working-aged males, which is the highest risk group for suicide death in Utah.
5. Through 2020, provide at least 3 evidence-based training and tools to behavioral health providers to increase their ability to effectively assess suicide risk, implement appropriate triage, counsel on reducing access to lethal means, engage the client in safety planning, and provide ongoing trauma-informed treatment in a manner that promotes healing and recovery.
6. Through 2020, five implementing agencies will provide adequate staffing and resources, including budget, facilities, staff development, and time to implement suicide prevention programs that effect youth.
7. Through 2020, continue to seek out additional funding and resources to implement suicide prevention activities at all levels by applying for at least three grants that would benefit the entire state.

8. Through 2020, define five areas of focus for the role of public health in suicide prevention and increase the number of public health partners that are active in suicide prevention activities by 10%.
9. Through 2020, continue statewide collaboration to successfully implement at least 80% of the activities and recommendations of the Utah Suicide Prevention Plan.
10. Through 2020, continue to promote at least 5 suicide public awareness events sponsored by organizations such as NAMI Utah, Utah Chapter of the Mental Health Association, and the American Foundation for Suicide Prevention.
11. By 2020, identify at least 2 systems and agencies that can increase evaluation of the effectiveness and efficiency of the suicide prevention programs and interventions that are available in Utah, and complete at least 2 evaluation projects.
12. Through 2020, increase access to two suicide prevention programs and two mental health or suicide prevention resources in rural and frontier areas of the state that target resource and prevention gaps as identified by local coalitions and agencies.

Objective 4: By the end of 2020, continue to update and implement at least two training guides/materials for health care providers, the media, clergy, or other identified groups that address suicide risk factors, treatment for suicidal thoughts, and reporting suicides.

Activities

1. By 2020, update existing "pocket card" for reporting on violent deaths. Disseminate pocket card and train at least 50 Utah investigators and medical examiners in comprehensive interviewing techniques and reporting needs in order to improve quality of data gathered for violent deaths and suicides.
2. By 2020, define minimum course objectives addressing suicide risk and protective factors for health care provider and counseling training/graduate programs; and share with at least five relevant agencies.
3. Through 2020, continue to educate, support, and involve family members regarding risk and protective factors for suicide, warning signs of suicide, and resources, using at least 20 research-informed media messages.
4. Through 2020, train 5 additional local media representatives to promote accurate, responsible, and hopeful representation of suicidal behaviors, mental illness, and related issues in compliance with national reporting guidelines and Connect Suicide Postvention guidelines Increase the percentage of messages that provide positive narratives about resilience, recovery, treatment, and suicide prevention.
5. Through 2020, train at least 20 additional educational staff, healthcare providers, faith-based organizations, call centers, juvenile justice system professionals, youth-serving social service agencies, and law enforcement officers on identifying and responding to a youth in mental health crisis and/or at risk for suicide. Apply for and provide Continuing Education Units to at least 2 classes of professionals to incentivize professional development regarding suicide prevention topics.

6. Through 2020, continue to support all existing services to survivors of suicide loss, identify and increase at least one resource in rural areas for survivors of suicide loss, and investigate ways to increase outreach to families and youth after a suicide.
7. By 2020, pilot and evaluate at least one support group for suicide attempt survivors in Utah.
8. Through 2020, provide resources such as counseling on reducing access to lethal means, safety planning, and coping skills to teenagers who have attempted suicide through school counselors, emergency rooms, and behavioral health providers.
9. By 2020, investigate and pilot 2 evidence-based ways to provide support and care to clinicians, first responders, and medical professionals when a patient under their care dies by suicide.

Objective 5: By the end of 2020, access to mental health and substance abuse services will increase by 10%.

Activities
1. By 2020, implement guidelines for mental health assessment and treatment for suicidal individuals from adult and juvenile incarcerated populations in at least 5 facilities.
2. Through 2020, assess access to mental health care, and improve access to mental health care for uninsured and non-Medicaid population by ensuring that at least 50% of this population has access to mental health and psychiatric services.
3. Through 2020, provide referrals and resources for mental health services to the community by updating the Suicide Prevention Coalition's and Utah Department of Health's websites annually and releasing at least 50 media messages or print materials per year to promote resources (statewide and by county or small area).
4. By 2020, collect current information for mental health and crisis services in each county in Utah and annually update this resource list on the Utah Suicide Prevention Coalition and Utah Department of Health websites.
5. By 2020, distribute the policies and procedures of the UNI crisis response model to all local mental health authorities in Utah to provide them with strategies to increase the quality, capacity, and mobility of their 24-hour crisis care.
6. By 2020, develop and disseminate a protocol/guide based on the UNI Receiving Center and Wellness Recovery Center, to creating crisis and recovery centers as an alternative to Emergency Department care when appropriate, or as a residential level of care that facilitates return to community outpatient care (Objective 8.8 in the National Strategy).
7. Through 2020, conduct a literature review to create a best practice protocol for continuity of care, and provide training and information to at least 15 health and behavioral health agencies.
8. Through 2020, assess how many healthcare providers are currently engaged in the Zero Suicide Initiative and educate providers about the benefits and resources that the initiative provides, to improve the policies and infrastructure of the healthcare and behavioral health systems at all stages of suicide prevention and intervention, and highlight successful systems and programs.

9. Educate physicians on suicide risk assessment in older adults and increase the number of health systems using evidence based screening tools for depression and suicide by one.

Implementing Organizations
- Faith-based organizations
- Juvenile and Adult Corrections
- Local colleges and universities
- National Alliance on Mental Illness – Utah
- American Foundation for Suicide Prevention
- Utah Department of Health
    - Bureau of Maternal and Child Health
    - Violence and Injury Prevention Program
- Utah Department of Human Services
    - Division of Substance Abuse and Mental Health
- Utah's local health departments
- Utah's hospitals and healthcare providers
- Local non-profit organizations
- Local mental health providers

Evidence-based Interventions/Best Practices
- Community Trials Intervention To Reduce High-Risk Drinking http://www.pire.org/communitytrials/index.htm
- Emergency Department Means Restriction Education http://nrepp.samhsa.gov/ViewIntervention.aspx?id=15
- Emergency Room Intervention for Adolescent Females http://chipts.ucla.edu/interventions/manuals/interer.html
- Seeking Safety http://www.seekingsafety.org
- United States Air Force Suicide Prevention Program http://nrepp.samhsa.gov/ViewIntervention.aspx?id=121
- Challenging College Alcohol Abuse http://www.socialnorms.campushealth.net, http://www.health.arizona.edu
- Coping With Work and Family Stress http://www.theconsultationcenter.org/index.php?/coping-with-work-a-family-stress.html
- **Suicide Prevention Resource Center Best Practices Registry //www.sprc.org/bpr/section-i-evidence-based-programs**
- **Suicide Prevention Resource Center Expert/Consensus Statements** http://www.sprc.org/bpr/section-ii-expertconsensus-statements
- **American Foundation for Suicide Prevention Education and Prevention Programs** https://www.afsp.org/preventing-suicide/our-education-and-prevention-programs

- www.reportingonsuicide.org

Ages 65+

Falls

Overview

Falls are the most common cause of injury hospitalization and the leading cause of injury death for Utahns aged 65 and older. Unintentional falls caused 631 unintentional fall-related deaths in Utah from 2011-2013; during 2011-2013, there were 15,796 unintentional fall-related hospitalizations in the state. Utah's overall age-adjusted rate for unintentional fall injury hospitalization during 2011-2013 was 22.6 per 10,000 population. More than 80% (515/631) of the deaths and more than 60% (9,523/15,796) of the hospitalizations were among Utahns aged 65 and older.[95]

Falls can have a significant impact on an individual's health and well-being. It is estimated that each year, 1 in 500 Utahns age 65 and older will be hospitalized from a traumatic brain injury (TBI) resulting from a fall. Only about one-third of older adults in Utah who sustained a TBI due to a fall and required at least hospitalization returned home under self-care. Most required on-going care either in-home or at another facility and about 13.7% died during from their injury.[96] Hip fractures are also serious fall injuries.[97] Nationally, one out of five hip fracture patients will die within a year of their injury.[98]

There is a greater percentage of emergency department (ED) visits due to unintentional falls than fall-related hospitalizations or deaths among Utahns age 65 and older (Figure X).

Figure X

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[95] *IBIS Health Indicator Report of Fall Injury*
[96] *2008 Utah Traumatic Brain Injury Surveillance System, Falls Module*
[97] *Stevens JA. Falls Among Older Adults—Risk Factors and Prevention Strategies. In: Falls Free: Promoting a National Falls Prevention Action Plan: Research Review Papers. NCOA Center for Healthy Aging, 2005. pp 3–18.*
[98] *Leibson CL, Toteson ANA, Gabriel SE, Ransom JE, Melton JL III. Mortality, disability, and nursing home use for persons with and without hip fracture: a population-based study. Journal of the American Geriatrics Society 2002;50:1644–50.*

Percentage OF Deaths, Hospitalizations, And Emergency Department Visits For Falls, Utah, 65+, 2010-2013
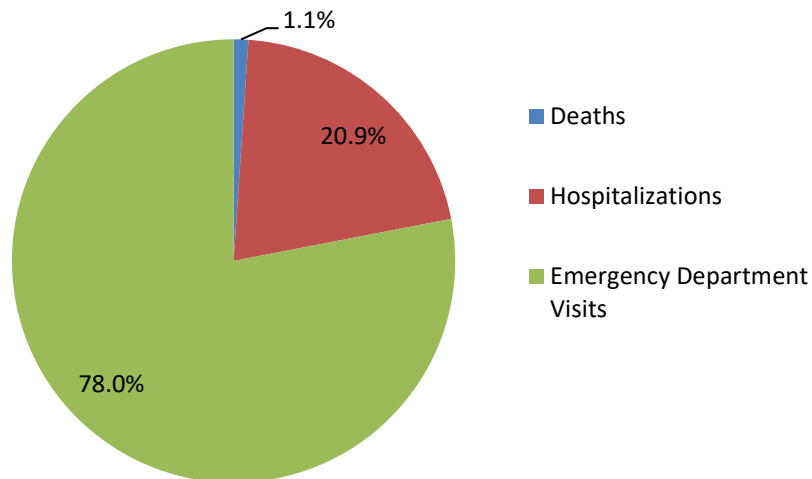
From 2010-2013 the rate of ED visits due to unintentional falls among Utahns aged 65 and older was 443.98 per 10,000 population.[13] For hospitalizations, the rate was 118.81 falls per 10,000 population.[99] For fall-related deaths, the rate was 61.04 deaths per 100,000 population.[100]

From 2011-2013 the Utah crude rate of unintentional fall hospitalizations was lower than the U.S. rate. The Utah fall hospitalization rate was 119.20 per 10,000 population and the U.S. rate was 150.20 per 10,000[101] (Figure X).
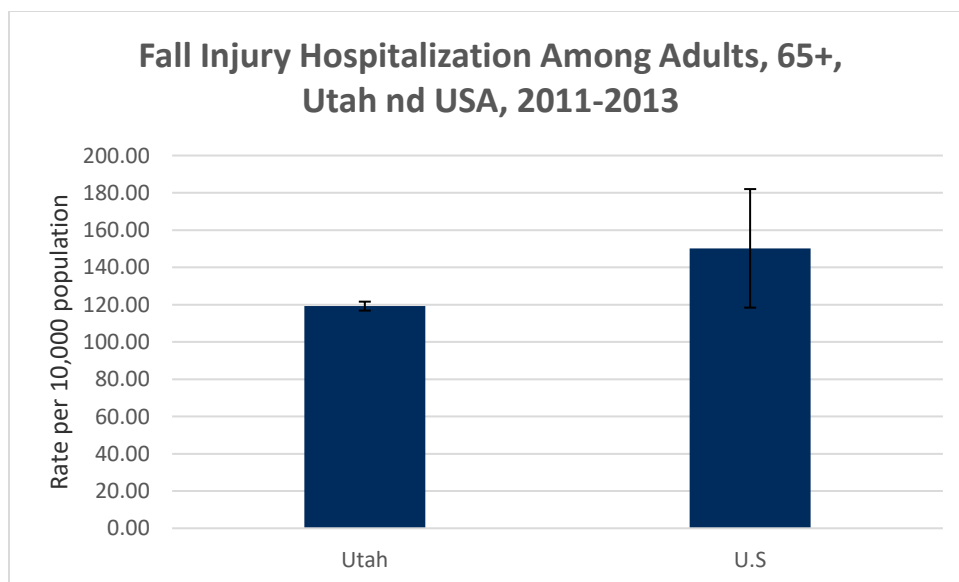
Figure X

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[13] IBIS-PH
[99] IBIS-PH
[100] IBIS-PH
[101] WISQARS

Fall Injury Hospitalization Among Adults, 65+, Utah nd USA, 2011-2013

Chart: Bar chart showing "Rate per 10,000 population" on the y-axis (0.00 to 200.00) with two bars. Utah is approximately 120 and U.S is approximately 150, both with error bars.

Data, Surveillance and Costs

Geographic Data

Between 1992-2013, urban counties had consistently higher rates of unintentional fall hospitalizations than rural and frontier counties. From 2003-2007, Southeastern Health District (HD) had the highest rate of ED visits due to unintentional falls among Utahns aged 65 and older at 423.8 per 10,000 population. Salt Lake Valley HD had the highest rate of fall hospitalizations at 141.8 per 10,000 population. Central Utah HD had the highest rate of fall-related deaths at 47.6 per 100,000 population.

Among Utah's small areas, Carbon/Emery Counties had the highest rate of ED visits at 542.9 per 10,000 population. South Jordan had the highest rate of fall hospitalizations at 208.8 per 10,000 population and Midvale had the highest rate of deaths at 85.5 per 100,000 population.

Other HDs and small areas with significantly higher and lower unintentional fall ED, hospitalization, and fatality rates than the state rate can be found in Appendix X.

Age and Sex

Among Utahns aged 65 and older, females are injured more often in falls than males, but males have a higher percentage of falling and die more often from their injuries.[102] Approximately 20.3% of men and 40.1% of women reported being injured seriously enough to limit regular activities for at least a day or to see a doctor.[103] Elderly females (ages 75 and older) have a

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[102] *Utah Inpatient Hospital Discharge Data, Office of Health Care Statistics, Utah Department of Health, 2006*
[103] *2003 and 2006 Utah BRFSS*

significantly higher fall hospitalization rate than males. The percentages of falling appear to increase with age among men but remain fairly stable among women[104] (Figure X).

Figure X

Number Of Fall Hospitalizations By Age Group And Sex, Utah, 65+, 2013
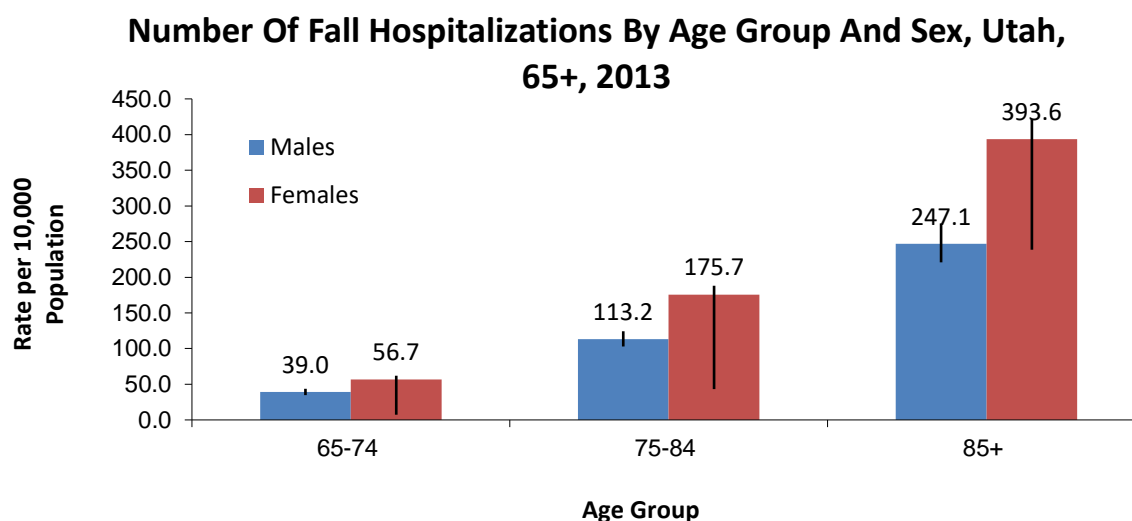
Costs
The total hospitalization charges from 2003-2007 for unintentional fall hospitalizations among Utahns aged 65 and older was over $252 million.[105] Nationally, the cost of fatal fall injuries totaled $349 million and $6.3 billion for ED visits. [106]

Healthy People 2020 Objectives
- IVP-23   Prevent an increase in the rate of fall-related deaths
- OA-5   Reduce the proportion of older adults who have moderate to severe functional limitations
- OA-6   Increase the proportion of older adults with reduced physical or cognitive function who engage in light, moderate, or vigorous leisure-time physical activities
- OA-11   Reduce the rate of emergency department visits due to falls among older adults

Prevention Strategies

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[104] *2003 and 2006 Utah BRFSS*
[105] *IBIS*

[106] *Cost of Fall Injuries in Older Persons in the United States, 2005*
http://www.cdc.gov/HomeandRecreationalSafety/Falls/data/cost-estimates.html#links

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Goal 1: Policy

To provide information to organizational, local and state leaders resulting in legislation, regulations, and policies that address falls prevention interventions.

Objective 1: Develop a falls prevention agenda.

Activities

1. Assemble falls advocacy group.

2. Identify and prioritize falls issues annually that could be addressed by policy initiatives.

3. Identify local champions.

4. Charge fall prevention coalition members with advocating through his/her agency/organization, etc.

5. Develop falls fact sheet for legislators.

Objective 2: Annually compile federal, state and local statutes, etc.

Activities

1. Identify current rules, regulations, ordinances, etc. that support or are contrary to falls prevention tenets.

2. Identify policy agendas of partner organizations.

3. Identify existing surveys and needs assessments.

4. Identify proposed legislation currently being considered.

Objective 3: Increase knowledge of falls risk factors and prevention strategies among policy makers.

Activities

1. Identify and meet with stakeholders at federal, state and local levels.

2. Identify supporters/adversaries of mandates.

3. Partner with Falls Prevention Coalition to educate policy makers on the importance of falls prevention.

4. Create messages that the public can use to advocate with stakeholders.

5. Develop key messages regarding falls to address legislators/policy makers.

6. Provide/develop recommendations to legislators/policy makers

Objective 4: Propose at least one fall prevention related legislation policy to be considered for adoption.

Activities

1. Identify potential policy issues that could be addressed by legislation.

Goal 2: Education/Awareness for Older Adult Falls Prevention

Improve the falls prevention knowledge and behaviors among seniors and caregivers through community education and awareness efforts.

Objective 1: To increase knowledge of risk factors, prevalence, consequences, and prevention strategies among community members and seniors.

Activities

1. Maintain VIPP website content that provides tools for risk assessment, prevention tips, and links to community resources.

2. Link with partnered organizations and agencies' websites.

3. Encourage local health departments and Area Agencies on Aging to promote falls prevention messages/campaigns with a special emphasis on Fall Prevention Awareness Day/Week.

4. Charge fall prevention coalition members with advocating through his/her agency/organization, etc.

Objective 2: Develop social marketing campaigns for falls prevention.

Activities

1. Examine successful social marketing campaigns for falls prevention.

2. Adapt and adopt appropriate strategies for Utah.

3. Determine messages that resonate with specific high-risk groups.

Objective 3: Promote use of 2-1-1 centers for falls prevention interventions.

Activities

1. Provide 2-1-1 centers information on evidence-based community classes and home safety modifications for falls prevention.

2. Encourage local health departments, Area Agencies on Aging, EMS and healthcare organizations to distribute to 2-1-1 information to older adults and their family members/caregivers.

Objective 4: Increase awareness of older adults with TBI

Activities:

1. Examine successful social marketing campaigns for TBI; Adapt and adopt appropriate strategies for Utah specific to older adults.

2. Coordinate an education campaign with partners to promote awareness of TBI in older adults among caregivers and health care providers.

Goal 3: Infrastructure/Sustainability

To create a sustainable system which identifies needs, existing resources and gaps.

Objective 1: Maintain a statewide falls prevention coalition.

Activities

1. By 2016, form subcommittees as desired by the coalition to implement falls prevention strategies and activities.

2. Through 2020, convene quarterly coalition meetings.

3. Through 2020, distribute yearly satisfaction surveys to 100% of coalition members.

Objective 2: Identify and implement a continuum of evidence-based community falls prevention programs that target older adults with differing functional abilities.

Activities

1. Conduct a statewide assessment of falls prevention resources and interventions.

2. Evaluate the effectiveness of Stepping On and other falls prevention programs.

3. Explore the feasibility of implementing additional evidence-based community programs through local health departments and Area Agencies on Aging.

Objective 3: Promote state-wide advocacy initiatives driven by falls state advocacy group.

Activities

1. Create a framework for local/community organizations to adopt fall prevention initiatives.

2. Act as a resource for local/community organizations.

Objective 4: Diversify funding for evidence-based community falls prevention programs.

1. Partner local Medicare Advantage plans to promote and evaluate outcomes of Stepping On and other evidence-based community programs.

2. Collaborate with Utah Medicaid to address falls prevention within the New Choices Waiver and Aging Waiver programs.

3. Educate policy makers on the importance of falls prevention.

Objective 4: Identify and address gaps in current falls prevention resources.

Activities

1. Compile and compare falls prevention resources within each local health district.

2. Share resource information between local health districts.

Goal 4: Engage healthcare providers and healthcare systems to improve falls prevention assessment and intervention in healthcare settings.

Objective 1: Develop and implement a falls prevention education strategy to increase awareness among healthcare providers.

Activities

1. Encourage healthcare providers to follow published evidence-based guidelines for falls risk screening and intervention.

2. Maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate falls data.

Objective 2: Train new healthcare professionals on the importance of falls risk management.

Activities

1. Encourage health education programs to include evidence-based falls risk screening and intervention guidelines in their curriculum.

2. Provide information on evidence-based fall prevention community programs to health education programs.

Goal 5: Engage healthcare providers and healthcare systems to increase TBI assessment post fall.

Objective 1: Promote the use of evidence based screening tools for TBI.

Activities

1. Educate healthcare providers and healthcare systems on prevalence of TBI in older adults and the need to screen for TBI.

2. Encourage healthcare providers, long term care facilities and healthcare systems to follow best practice guidelines for TBI screening.

Objective 2: Continue to monitor and publish TBI data in Utah to determine trends and monitor progress.

Activities

1. Maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate falls data.

2. Update and publish Older Adult TBI fact sheet.

Objective 3: Increase referrals for appropriate services and rehabilitation for TBI.

Activities

1. Increase awareness and referrals for resource facilitation among older adults with TBI.

2. Promote media campaign to target children of older adults for TBI risk and awareness.

Implementing Organizations

- Intermountain Healthcare
- University of Utah
    - o Center on Aging
    - o College of Nursing
    - o Department of Physical Therapy o Division of Geriatrics
    - o Division of Occupational Therapy
- University of Utah Faint and Falls Clinic
- Utah's Area Agencies on Aging
- Utah Association for Home Care
- Utah Coalition for Caregiver Support
- Utah Commission on Aging
- Utah Division of Aging and Adult Services
- Utah Department of Health
    - o Arthritis Program
    - o Physical Activity, Nutrition, and Obesity Program of Violence and Injury Prevention Program
- Utah Health Care Association
- Utah's 12 Local Health Departments
- Utah Pharmacists Association
- Utah Physical Therapy Association
- VA Medical Center
- Utah Brain Injury Council
- Brain Injury Alliance of Utah

Evidence-based Interventions/Best Practices

- Preventing Falls: What Works, A CDC Compendium of Effective Community-based Interventions from around the World
  www.cdc.gov/HomeandRecreationalSafety/images/CDCCompendium_030508 -a. pdf.
- A Matter of Balance program
  www.healthyagingprograms.com/content.asp?sectionid=69&ElementID=489
- CDC Healthy Aging Research Network www.prc-han.org/
- National Council on Aging www.ncoa.org/
- Center for Healthy Aging fall prevention
 www.healthyagingprograms.com/content.asp?sectionid=69

Motor Vehicle Crashes

Overview

Motor vehicle crashes[106] (MVC) are the second leading cause of injury death, behind poisoning, for all ages in Utah. Motor vehicle crashes may include occupants in motor vehicles (driver and passengers), motorcyclists, bicyclists, pedestrians, and All Terrain Vehicle/Off Highway Vehicles (ATV/OHV).

Utah's rate of MVC traffic[107] occupants[108] deaths decreased since 2006 (Figure X).
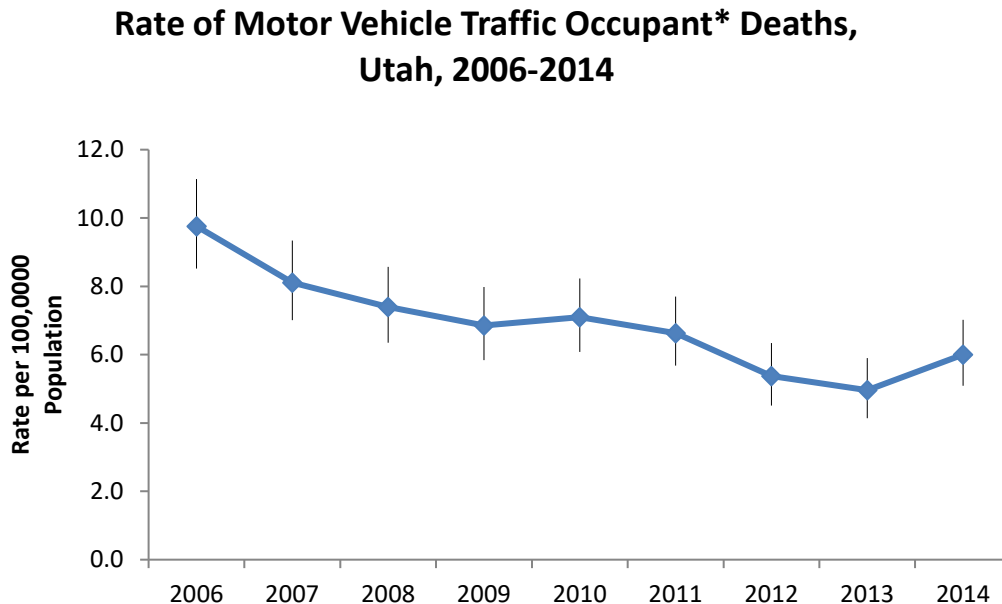
Figure X

Rate of Motor Vehicle Traffic Occupant* Deaths, Utah, 2006-2014

*Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators

However, motorcyclist[109] , bicyclist[110] , pedestrian[111] , and ATV/OHV[112] deaths have remained fairly consistent during this time (Figure X).

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[106] Motor Vehicle Crashes include eight indicators on IBIS: 1) MV traffic-occupant injured, 2) MV traffic-motorcyclist injured, 3) MV traffic-pedal cyclist injured, 4) MV traffic-pedestrian injured, 5) MV traffic-other and unspecified, 6) pedal cyclist MV non-traffic and other, 7) pedestrian MV non-traffic and other, and 8) other MV non-traffic and other.
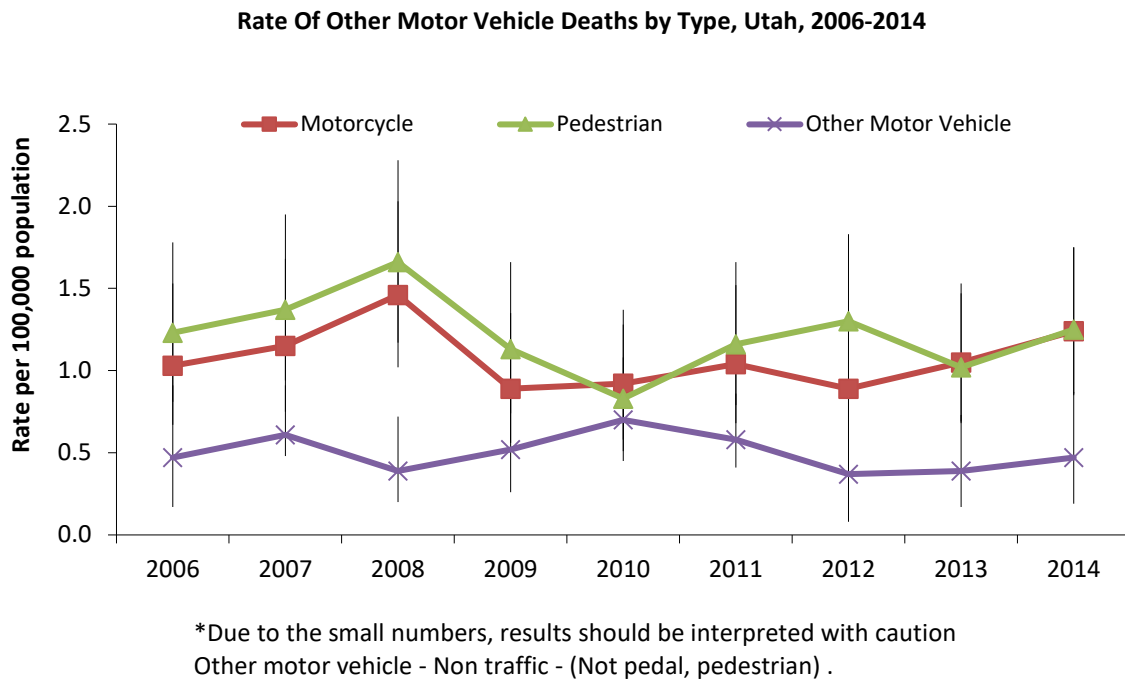*[107] MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified.*
[108] Occupants include those in the MV traffic-occupant injured and MV traffic-other and unspecified indicators.
[109] Motorcyclists include those in the MV traffic-motorcyclist injured indicator.
[110] Bicyclists include those in the MV traffic-pedal cyclist injured and pedal cyclist MV non-traffic and other indicators.

Figure X

Rate Of Other Motor Vehicle Deaths by Type, Utah, 2006-2014

*Due to the small numbers, results should be interpreted with caution
Other motor vehicle - Non traffic - (Not pedal, pedestrian) .

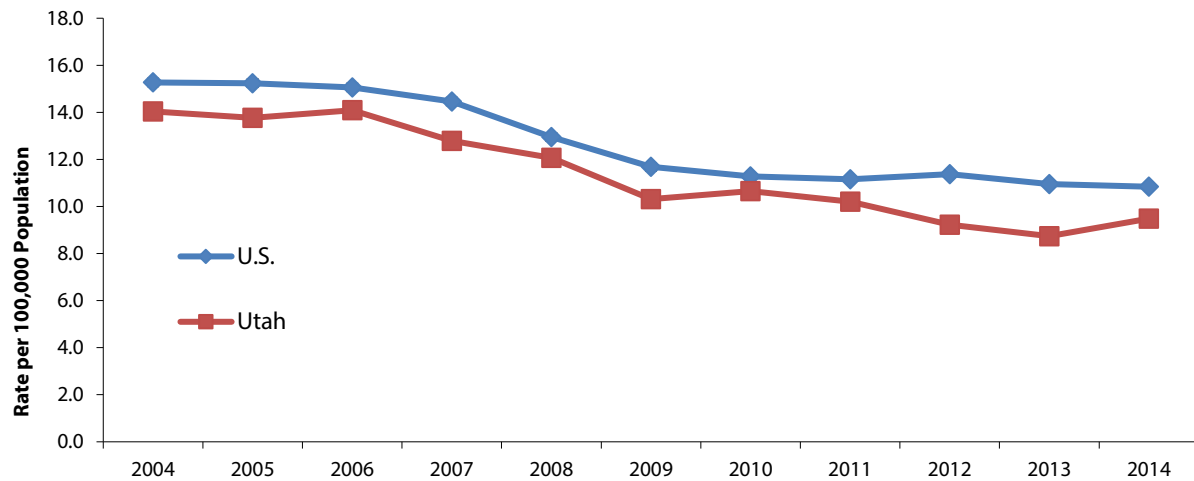Since 2006, Utah has had a lower MVC traffic death rate than the U.S. (Figure X).[113]

Figure X

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[111] *Pedestrians include those in the MV traffic-pedestrian injured and pedestrian MV non-traffic and other indicators.*
[112] *ATV/OHV deaths include those in other MV non-traffic and other indicator.*
[113] *WISQARS*

Rate of Motor Vehicle Traffic* Deaths, Utah and U.S., 2004-2014

*MV traffic includes five indicators: 1) MV traffic-occupant injured, MV traffic-motorcyclist injured, MV traffic-pedal cyclist injured, MV traffic-pedestrian injured, and MV traffic-other and unspecified

In 2014, Utah's MVC traffic death rate for all ages was 8.16 per 100,000 population compared to the U.S. age-adjusted MVC death rate of 10.58 per 100,000 population. [114]

Data, Surveillance and Costs

Geographic

In 2014, Weber-Morgan HD had the highest MVC traffic ED visit rate for all ages at 73 per 10,000 population among local health districts. Tooele HD had the highest MVC traffic hospitalization rate for all ages at 6.01 per 10,000 population while Tricounty HD had the highest MVC traffic death rate for all ages at 25.7 per 100,000 population among local health districts.

Other HDs and small areas with significantly higher and lower MVC rates than the state rate can be found in Appendix X.
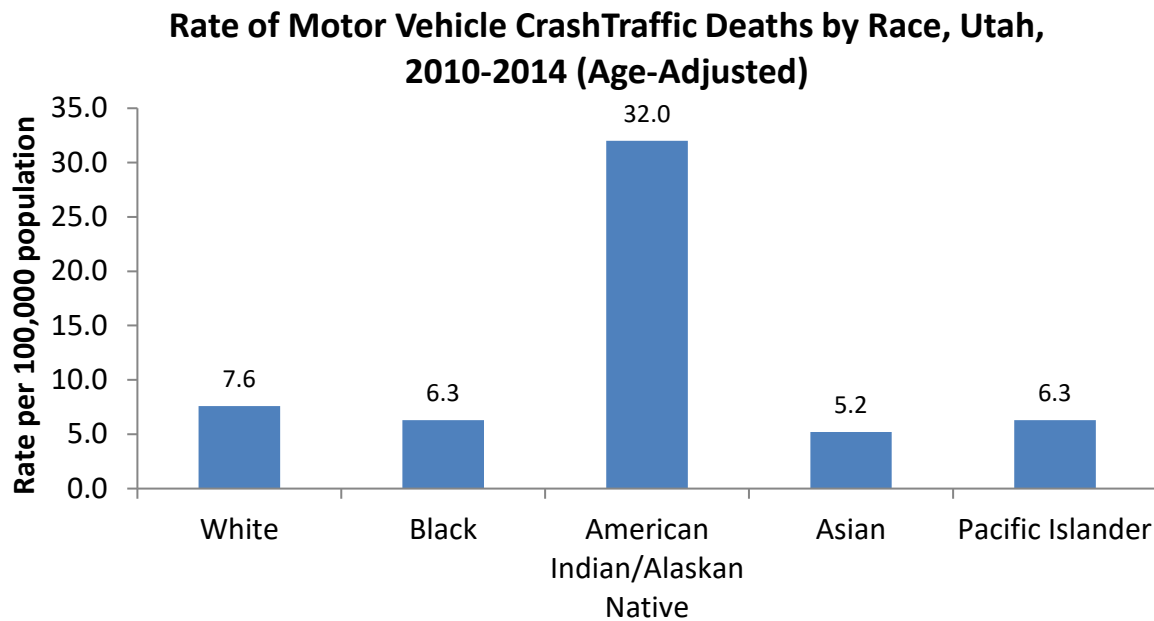
Race and Ethnicity[115]

From 2010 - 2014, American Indians/Alaskan Natives (32.0 per 100,000 population) had a higher rate of MVC traffic deaths than White persons (7.6 per 100,000 population) and Black persons (6.3 per 100,000 population) (Figure X). However, statistical significance could not be calculated because case-level data was not available.

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[114] *WISQARS*
[115] *WISQARS, data years 2001-2005*

Figure X

Rate of Motor Vehicle CrashTraffic Deaths by Race, Utah, 2010-2014 (Age-Adjusted)

Healthy People 2020 Objectives
- IVP-13   Reduce motor vehicle crash-related deaths
- IVP-14   Reduce nonfatal motor vehicle crash-related injuries
- IVP-15   Increase use of safety belts
- IVP-16   Increase age-appropriate vehicle restraint system use in children
- IVP-18   Reduce pedestrian deaths on public roads
- IVP-19   Reduce nonfatal pedestrian injuries on public roads
- IVP-20   Reduce pedal cyclist deaths on public roads
- IVP-21   Increase the number of States and the District of Columbia with laws requiring bicycle helmets for bicycle riders
- IVP-22   Increase the proportion of motorcycle operators and passengers using helmets

Prevention Strategies

The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Goal: Reduce injuries and deaths from motor vehicle crashes in Utah.

Objective 1: Implement at least one evidence-based or best practice program for older drivers in community settings and/or healthcare provider offices.

Activities

1. By 2019, expand child passenger safety programs to reach at least 500 older adults through senior centers, grandparents, and other child caregiver programs.
2. Through 2020, increase collaboration with state and local aging service programs.
3. By 2019, identify and implement evidence-based or best practice programs for older drivers in senior centers and assisted living centers.
4. Promote use of AARP's resources and educational materials for older adult drivers and their family members.
5. By 2020, develop media campaigns to increase awareness among children of older drivers on recognizing signs of unsafe driving behaviors in their parents and resources that can help them make alternative transportation arrangements or safe driving practices.
6. Through 2020, distribute the American Medical Association "Physician's Guide to Assessing and Counseling Older Drivers" guidelines to healthcare providers.
7. By 2020, increase overall educational outreach efforts through healthcare provider offices.
8. By end of 2020, evaluate evidence-base or best practice programs and educational outreach efforts.

Objective 2: Continue surveillance of MVC injuries and deaths.

Activities

5. Through 2020, ensure capacity for the production and dissemination of motor vehicle crash-related publications.
6. Through 2020, collaborate with the Utah Highway Safety Office to identify and target surveillance data for specific audiences (e.g., policymakers, local health departments, etc.)
7. Through 2020, maintain publicly accessible data query system through the Indicator Based Information System for Public Health (IBIS-PH).
8. Through 2020, leverage existing surveillance systems and data sources to collect motor vehicle crash-related data.
   a. Driving behaviors through BRFSS
   b. Impaired driving, specifically opioid intoxication in fatal crashes (UTVDRS)
   c. General crash fatality data FARS/NVDRS
9. Through 2020, develop and update fact sheets and data reports on an annual basis.

Objective 3: Enact policies/legislation regarding motor vehicle safety.

1. Through 2020, increase education to elected officials and policy makers on motor vehicle-related trends and challenges through a minimum of two fact sheets, briefings, or other educational activities.
2. Through 2020, provide at least two data-driven fact sheets on MVC-related legislation to advocates, Utah Legislature, and other stakeholders.
3. By 2018, complete an evaluation of the Primary Seatbelt Law.
4. By 2019, work with stakeholders to help make the Primary Seatbelt Law permanent.
5. By 2020, pass legislation banning hands-free use of cell phones while driving for all ages.
6. Through 2020, evaluate and support policies/legislation regarding distracted driving, impaired driving, drowsy driving, and aggressive driving.
7. Through 2020, continue to enforce handheld cell-phone-use-while-driving ban law.
8. By end of 2020, pass legislation requiring drivers to retake the written driving exam at specified intervals.
9. Yearly, through 2020, promote workplace policies prohibiting employees from using cell phones while driving on company business.

Implementing Organizations

- American Automobile Association (AAA), Utah chapter
- AARP, Utah chapter
- Insurance companies
- Law enforcement agencies
- Utah's 12 Local Health Departments
- Utah Department of Public Safety
  - Utah Highway Safety Office
- Utah Department of Health
  - Violence and Injury Prevention Program
- Utah Department of Transportation
- Utah Safety Council
- Zero Fatalities campaign

Evidence-based Interventions/Best Practices

- AAA Senior Drivers program and materials www.seniordrivers.org/home/
- American Association of Retired Persons materials http://www.aarp.org/home-family/getting-around/driving-resource-center/driver-resources/
- American Medical Association http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health.page
- Zero Fatalities http://ut.zerofatalities.com/

Suicide Attempts and Fatalities

Overview

From 2012-2014, Utah's age adjusted suicide rate was 20.8 per 100,000 persons. All suicide attempts should be taken seriously. Completed suicides are only part of the problem. More people are hospitalized or treated in an emergency room for suicide attempts than are fatally injured. In 2013, 13 Utahns were treated for self-inflicted injuries every day (3,181 emergency department visits and 1,508 hospitalizations).[116]

**Data, Surveillance and Costs**

Geographic Data

Central and Southeastern Utah Health Districts (HD) had the highest suicide death rates for all ages among local health districts at 24.8 per 100,000 population. Carbon/Emery Counties had the highest suicide death rate at 28.1 per 100,000 population among small areas.

Other HDs and small areas with significantly higher and lower suicide attempts and suicide death rates than the state rate can be found in Appendix X.

Age and Sex

Males 65 years and older have a significantly higher suicide rate than females 65 years and older (41.9 and 5.44 per 100,000 population) (Figure X).
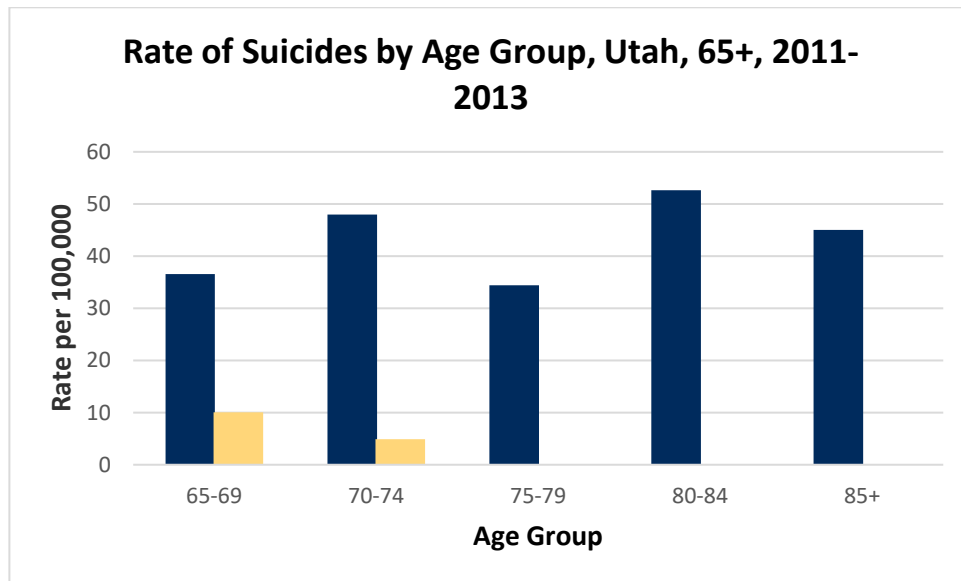
Figure X

Rate of Suicide by Sex, Utah, 65+, 2011-2013

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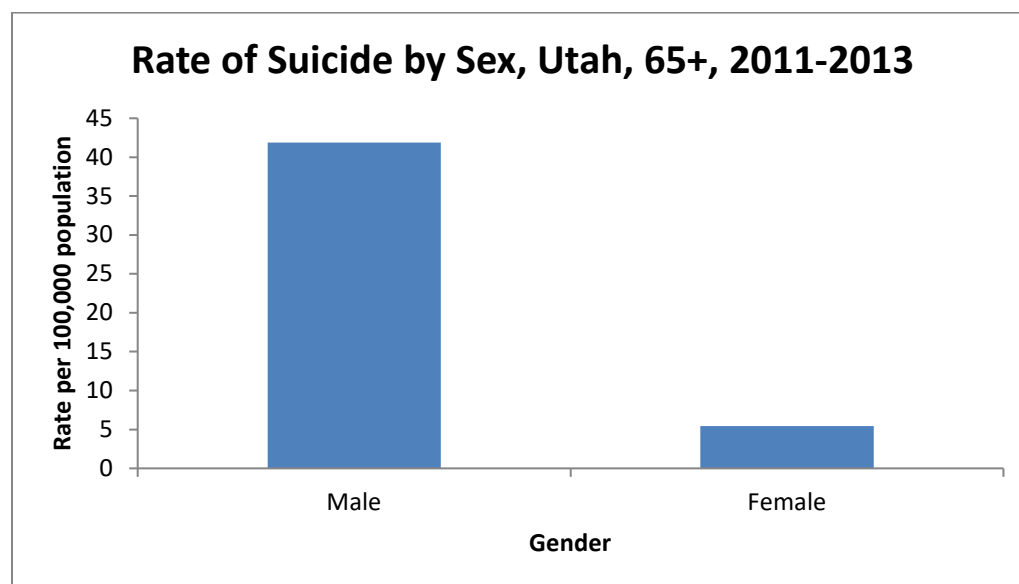
[116] *IBIS*

When broken down by age group, 85-84 year old males (52.64 per 10,000 population) had the highest suicide fatality rate, which is significantly higher than the overall elderly male suicide rate (41.9 per 100,000 population) (Figure X).

Figure X

Rate of Suicides by Age Group, Utah, 65+, 2011-2013

*Insufficient number of cases to meet the UDOH standard for data reliability; interpret with caution.

Method of Self-inflicted Injury
The most common method of injury for older adult suicides was firearm for males and poisoning for females.

Healthy People 2020 Objectives
- **IVP-41**   Reduce nonfatal intentional self-harm injuries
- **MHMD-1**   Reduce the suicide rate

Prevention Strategies
The Injury Community Planning Groups (ICPG), ICPG Subcommittees, and VIPP staff identified the following prevention strategies. Organizations charged with taking the lead on implementation of these objectives and activities were also identified and listed under "Implementing Organizations."

Goal: Decrease the number of suicides among males 65 and older.

Objective 1: By the end of 2020, information from surveillance data, in the form of fact sheets and/or reports, will be disseminated to appropriate stakeholders.

Activities

1. By 2020, continue to work with existing partners and identify 2 additional users of information, assess their needs, and prioritize according to the results of the assessment (i.e. adult protection services, mental health facilities, skilled care or rehabilitation facilities).
2. By 2020, evaluate the Utah Violent Death Reporting System and the Behavioral Risk Factor Surveillance System for their usefulness in monitoring utilization of mental health and substance use services, risk and protective factors for suicide, suicide ideation, suicide deaths, and attempted suicides in Utah.
3. By 2018, develop a list of at least two data needs that are not covered by existing data sources.
4. By 2020, add at least two suicide components to existing data collection systems to gather more complete information about populations at risk for suicide, to screen for distress and dysfunction associated with mental illness, and to close gaps in suicide data collection.
5. By 2020, collaborate with partners such as Law Enforcement and the LGBT Committee of the Utah Suicide Prevention Coalition to determine and implement methods to collect, analyze, and interpret more comprehensive data relating to LGBT risk factors, suicide attempts, and death rates in Utah.
6. Through 2020, maintain current level of epidemiological and support staff to collect, analyze, interpret, and evaluate suicide data.
7. By 2020, organize and implement at least one Suicide Fatality Review Committee involving key partners, and regularly share recommendations from the committee with agencies in Utah.
8. By 2020, develop a Utah suicide prevention research agenda with comprehensive input from multiple stakeholders; then carry out at least one suicide prevention research/evaluation project and disseminate the results.
9. By 2020, identify ways to increase the tracking and coordination of statewide efforts in suicide prevention. By 2020, compile a summary report on progress made regarding the Utah Suicide Prevention Plan.

Objective 2: By the end of 2020, information from surveillance data, in the form of fact sheets, presentations, and/or reports will be disseminated to 500 appropriate stakeholders.

Activities
1. Through 2020, continue to evaluate at least three suicide data publications as to their usefulness in helping local health districts, and community-based organizations implement suicide prevention strategies.
2. Through 2020, ensure capacity for the production and dissemination of suicide data publications.

3. Through 2020, identify and target surveillance data for at least five specific audiences (e.g., policy makers, schools, local health departments, agencies serving at-risk populations, etc.)
4. Through 2020, improve the availability and accessibility of surveillance data for specific audiences (e.g., policymakers, healthcare providers, local health departments, etc.)
5. Through 2020, disseminate at least two suicide fact sheets on suicide in older adults.

Objective 3: By the end of 2020, continue to update and implement training guides/materials for health care providers, the media, clergy, or other identified groups that address suicide risk factors, treatment for suicidal thoughts, and reporting suicides.

Activities

1. By 2020, continue to promote efforts to reduce access to lethal means and methods of self-harm (including firearms, drugs, and poisons) through distribution of at least 5,000 firearm locks and brochures and through promoting at least 10 messages relating to means restriction.
2. Through 2020, continue to support at least 4 existing conferences that specifically address suicide; and promote/support opportunities for 4 additional Utah conferences to address evidence-based suicide prevention, intervention, and postvention strategies.
3. Through 2020, continue to support and expand implementation of best practice suicide prevention and postvention programs being offered throughout the state, such as QPR, safeTALK, Mental Health First Aid, ASIST, Signs of Suicide, More Than Sad and other programs created or supported by AFSP, Connect Suicide Postvention, etc., to reach at least 10,000 more Utahans by 2020.
4. By 2020, identify and increase implementation of 1 universal, primary prevention strategy for suicide prevention among older adults that focuses on resiliency, social support and connectedness, problem-solving skills, and other protective factors.
5. Through 2020, continue to target healthcare providers in order to facilitate appropriate training in suicide prevention and increase the frequency of use of depression and suicide screening tools and referrals in the healthcare system by 20%.
6. Through 2020, provide at least 3 evidence-based training and tools to behavioral health providers to increase their ability to effectively assess suicide risk, implement appropriate triage, counsel on reducing access to lethal means, engage the client in safety planning, and provide ongoing trauma-informed treatment in a manner that promotes healing and recovery.
7. Through 2020, 5 implementing agencies will provide adequate staffing and resources, including budget, facilities, staff development, and time to implement suicide prevention programs.

8. Through 2020, continue to seek out additional funding and resources to implement suicide prevention activities at all levels by applying for at least three grants that would benefit the entire state, and include older adults in grant objectives and planning.
9. Through 2020, define 5 areas of focus for the role of public health in suicide prevention and increase the number of public health partners that are active in suicide prevention activities by 10%.
10. Through 2020, continue statewide collaboration to successfully implement at least 80% of the activities and recommendations of the Utah Suicide Prevention Plan.
11. Through 2020, continue to promote at least 5 suicide public awareness events sponsored by organizations such as NAMI Utah, Utah Chapter of the Mental Health Association, and the American Foundation for Suicide Prevention. .
12. By 2020, identify at least 2 systems and agencies that can increase evaluation of the effectiveness and efficiency of the suicide prevention programs and interventions that are available in Utah, and complete at least 2 evaluation projects.
13. By 2020, promote use of the SPRC-endorsed suicide prevention resources for older adults found at http://www.sprc.org/sites/sprc.org/files/OlderAdultSuicidePreventionResources.pdf to ten aging services providers.
14. Through 2020, increase access to two youth suicide prevention programs and two mental health or suicide prevention resources in rural and frontier areas of the state that target resource and prevention gaps as identified by local coalitions and agencies.

Objective 4: By the end of 2020, increase partnerships between school and community-based organizations to provide suicide prevention resources and services, and implement at least two trainings /materials for identified groups and agencies that address suicide risk factors, treatment for suicidal thoughts, and reporting on suicides.

1. By 2020, update existing "pocket card" for reporting on violent deaths. Disseminate pocket card and train at least 50 Utah investigators and medical examiners in comprehensive interviewing techniques and reporting needs in order to improve quality of data gathered for violent deaths and suicides.
2. By 2020, define minimum course objectives addressing suicide risk and protective factors throughout the lifespan for health care provider and counseling training/graduate programs; and share with at least 5 relevant agencies.
3. Through 2020, continue to educate, support, and involve family members regarding risk and protective factors for suicide, warning signs of suicide, and resources, using at least 20 research-informed media messages.
4. Through 2020, train 5 additional local media representatives to promote accurate, responsible, and hopeful representation of suicidal behaviors, mental illness, and related issues in compliance with national reporting guidelines and Connect Suicide Postvention guidelines Increase the percentage of messages that provide positive narratives about resilience, recovery, treatment, and suicide prevention.

5. Through 2020, train at least 20 additional groups of educational staff, healthcare providers, aging services, faith-based organizations, call centers, justice system professionals, workplaces, and law enforcement officers on identifying and responding to a person in mental health crisis and/or at risk for suicide. Apply for and provide Continuing Education Units to at least 2 classes of professionals to incentivize professional development regarding suicide prevention topics.
6. Through 2020, continue to support all existing services to survivors of suicide loss, identify and increase at least 2 resources in rural areas for survivors of suicide loss, and investigate ways to increase outreach to families after a suicide.
7. By 2020, pilot and evaluate at least one support group for suicide attempt survivors.
8. By 2020, investigate and pilot 2 evidence-based ways to provide support and care to clinicians, first responders, and medical professionals when a patient under their care dies by suicide.

Objective 5: By the end of 2020, access to mental health and substance abuse services will increase by 10%.

Activities

1. By 2020, implement guidelines for mental health assessment and treatment for suicidal individuals from adult and juvenile incarcerated populations in at least 5 facilities.
2. Through 2020, assess access to mental health care, and improve access to mental health care for uninsured and non-Medicaid population by ensuring that at least 50% of this population has access to mental health and psychiatric services.
3. Through 2020, provide referrals and resources for mental health services to the community by updating the Suicide Prevention Coalition's website annually and releasing at least 50 media messages or print materials per year to promote resources.
4. By 2020, collect current information for mental health and crisis services in each county in Utah and annually update this resource list on the Utah Suicide Prevention Coalition and Utah Department of Health websites.
5. By 2020, distribute the policies and procedures of the UNI crisis response model to all local mental health authorities in Utah to provide them with strategies to increase the quality, capacity, and mobility of their 24-hour crisis care.
6. By 2020, develop and disseminate a protocol/guide based on the UNI Receiving Center and Wellness Recovery Center, to creating crisis and recovery centers as an alternative to Emergency Department care when appropriate, or as a residential level of care that facilitates return to community outpatient care (Objective 8.8 in the National Strategy).

7. Through 2020, conduct a literature review to create a best practice protocol for continuity of care, and provide training and information to at least 15 health and behavioral health agencies.
8. Through 2020, assess how many healthcare providers are currently engaged in the Zero Suicide Initiative and educate providers about the benefits and resources that the initiative provides, to improve the policies and infrastructure of the healthcare and behavioral health systems at all stages of suicide prevention and intervention, and highlight successful systems and programs.
9. Educate physicians on suicide risk assessment in older adults and increase the number of health systems using evidence based screening tools for depression and suicide by one.

Implementing Organizations
- Utah Department of Health
- Violence and Injury Prevention Program
- Utah's Local Health Departments
- Department of Human Services
- Division of Substance Abuse and Mental Health
- Adult Protective Services
- National Alliance on Mental Illness – Utah chapter
- Faith-based Organizations
- Assisted Living Facilities, Senior Centers, Nursing Homes

Evidence-based Interventions/Best Practices
- Coping With Work and Family Stress, www.theconsultationcenter.org/index.php?/coping-with-work-a-family-stress.html
- http://www.samhsa.gov/
- http://impact-uw.org/
- http://www.sprc.org/sites/sprc.org/files/OlderAdultSuicidePreventionResources.pdf